STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NH
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are maintained on file in the New Hampshire Title V program's central office at:

Maternal and Child Health Section
NH DHHS
29 Hazen Drive
Concord, NH 03301

Assurances and certifications are available on request by contacting the New Hampshire Maternal and Child Health Section, Division of Public Health Services, Department of Health and Human Services at the above address, or by phone at 603-271-4517, by email at dlcampbell@dhhs.state.nh.us , or via the NH MCH website at: http://www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO/default.htm

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In this Title V Quinquennial Needs Assessment year, particular emphasis was placed on the inclusion of public and stakeholder input. The NH Title V Program, Maternal and Child Health Section (MCH) and Special Medical Services Section (SMS), through MCHB technical assistance, completed a CAST-5 process that included the participation of over 50 staff and stakeholders.

As a major component of the needs assessment, SMS completed a Delphi process, initiated for this purpose in 2001. Over 100 professionals and family members representing over 40 different constituent groups participated as key informants, as members of focus groups, and/or as survey respondents. Findings were reported in a widely distributed 2004 executive summary. Additionally, a survey of families of CSHCN receiving SSI for their own disability was conducted in 2004. Results of both processes are included in the Needs Assessment section of this application.

In culmination, MCH and SMS presented findings at a public input meeting to over 100 stakeholders, local agencies and parents from around the state. Participants were given the opportunity to express their opinions regarding New Hampshire's Title V priorities and local needs. This presentation is attached to this section.

This application is available on request through the DHHS website, at http://www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO/default.htm or by calling 603-271-4517.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

GEOGRAPHY

New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. It ranks 44th in area among the states and 19th in population density. New Hampshire's population is nearly equal to Maine and twice that of Vermont, but only 1/6 that of Massachusetts.(1) The population is estimated at 1.3 million in 2004, with 49% residing in rural areas and 51% in urban areas.(2) Seventy-seven percent of New Hampshire municipalities are considered non-urban or rural. Urban and near urban areas are located in the southeast and south central regions of the state, with primarily rural areas in the western, central and northern sections. The three most populous cities are Manchester, Nashua and Concord, all located in the southern third of the state. Manchester, the only city with a population over 100,000, is the largest city in northern New England. Hillsborough County includes the two largest cities of Manchester and Nashua and is the most densely populated area with 396,778 residents or 30.7% of the total population.(3) The White Mountain Nation Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as ‘the North Country', has the largest landmass of any county but the smallest population. New Hampshire citizens in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals.(4)

DEMOGRAPHICS

GENERAL: While New Hampshire's population growth rate exceeds that of all the New England states, it has slowed since 2000, and New Hampshire, along with Massachusetts, are the only New England states experiencing this decline.(5) The state's population is expected to increase by 12.1% between 2000 and 2010 and by 23.4% between 2000 and 2020. Population declines are expected only in Coos County between 2000 and 2010, followed by a return to 2000 levels by 2020.(6)

POPULATION BY AGE: New Hampshire's population, like that of the nation, is aging; with increases of 66% expected in the 55-64 year age group by 2010, and 121% in the 60-69 year age group by 2020. In 2004, the median age was 38.8, with an estimated 269,194 women of childbearing age (15-44 years) comprising 22% of the population. By 2020, women of this age group are expected to comprise 19% of the population. The total female population is expected to increase 12% by 2010 and 33% by 2020.(7) Today, children under 18 comprise 25% of the population, but it is estimated that by 2020 they will constitute just over 21%.(8)

RACE & ETHNICITY: New Hampshire's population was 95.1% White and non-Hispanic in the 2000 US Census, but is steadily becoming more racially and ethnically diverse. Since 1990, the Asian population, the state's largest racial minority, increased from 0.8% of the state's population to an estimated 1.7% in 2003, and the African-American population increased from 0.6% to and estimated 0.9%. Residents self-identifying as Hispanic or Latino comprised 1.8% of the population in 2003, compared to 1.0% in 1990.(9) Children with special health care needs comprise 15.2% of NH children under age 18 (n=47059) and reside in 23.4% of the state's households. (10)

New Hampshire is one of 30 states to have a dedicated Office of Minority Health. NH REACH 2010 Initiative data indicates that minority populations in the state have increased by 26% (Blacks/African American), 39% (American Indian), 71% (Asian) and 81% (Latinos) from 1990 to 2000. The White population increased by 8% during this period. African Descendents and Latinos differed substantially from Non-Hispanic Whites on most of the assessed health indicators. Of note, only 58% of African Descendents and 38% of Latinos reporting having health insurance. Disparities were also evidenced in body mass index and prevalence of diabetes.(11)

While 96% of New Hampshire children are White, the non-White population is expected to grow significantly in the coming years. Projections are that the Black and Hispanic child populations will

each have grown by 21%, and the Asian and Pacific Islander child populations will have grown by 30% between the years of 2000 and 2005. (12) The 2001 National Survey of CSHCN data for New Hampshire indicates that 91% of the children are White, 3% are Hispanic, 2% are multi-racial, 2% are Black, and 1% report as "other".

Seventy-eight percent of the state's minority populations reside in the three southern counties of Hillsborough, Rockingham and Strafford, 22% in Manchester and 19.5% in Nashua.(13) Community health agencies in these counties are increasingly aware of the linguistic and cultural needs of minority populations. Achieving cultural competence is more difficult for agencies in rural and non-urban areas where the numbers of minorities are smaller.

New Hampshire is also home to more than 6,500 refugees; 80 % reside in the state's southern tier. New Hampshire refugees come from over 30 nations. Of those settling in the state from 2000 to 2004, 45% were from Eastern Europe, 46% from Africa and 8% from the Middle East. (14) Among Manchester residents ages five and older, 19.6% spoke a language other than English at home, compared to 8.3% statewide.(15) While many of these new residents experience a range of health issues such as nutritional deficits, parasitic infestations, and communicable diseases, maternal and child health issues predominate. Case management, outreach and interpretation services are all in high demand for this population.

BIRTHS: New Hampshire's resident births peaked in 1989 at 17,801and declined by 19.2% to 14,383 in 2003. The birth rate decreased from 12.2 in 1997 to 11.2 in 2003. In 2003, New Hampshire had the 3rd lowest birth rate in the nation behind Maine and Vermont, 5.1% lower than the US non-Hispanic white rate of 11.8.(16) Given population projections and birth trends, it is clear that the state's demographics are changing.

TEEN & NONMARITAL BIRTHS: Similar to national rates, New Hampshire's teen birth rate has steadily decreased since 1990, when it was over 30 births/1000 females ages 15-19. In 2003, New Hampshire's teen birth rate had declined to 18.1, compared with the US white rate of 27.5.(17) In 2003, 5.7% of all births were to teens, a decreasing trend since 1997. A decrease in non-marital births occurred across all age groups and was highest among adolescents less than age 20, where 88.1% of births were to single mothers.(18) Health risks for teen mothers and their infants and the long-term negative socioeconomic implications are well known.

MATERNAL SMOKING: Maternal smoking, a significant risk factor affecting infant health, is a concern in New Hampshire. New Hampshire has experienced a decrease in maternal smoking, from 17.4% in 1997 to 14.2% in 2003. Smoking among teen mothers decreased as well, from 37.9% in 1997 to 34.4% in 2003, but remains more than double that of all mothers combined.(19)

PRENATAL CARE & INFANT HEALTH: Contrary to the decline in teen births and maternal smoking, New Hampshire has experienced a steady increase in LBW and premature births, highest among adolescent mothers. The 1997 state infant mortality rate (IMR) of 4.4 was the lowest ever and the lowest overall white IMR nationally. The state ranked 3rd for low birth weight (LBW) rates in 1997, with a rate of 5.9 compared to the U.S. white rate of 6.5. New Hampshire was also among the top three states in adequacy of prenatal care measures. In 1997, late or no prenatal care comprised 1.5% of all births compared with the national white rate of 3.2%.(20)

Provisional vital statistics indicate the IMR for NH in the 12-month period ending November 2004 was 5.6 (N=83), an increase from the 2003 rate of 3.8 (N=55) during the comparable period (21). The 2002 rate for this period was 5.3 (N=77) (22). The U.S. rate was higher and ranged from 6.9 in 2002 to 6.6 in 2003.

Infant Mortality Rate
Nov. ‘03-Nov. ‘04 Nov. ‘02-Nov. ‘03 Nov. ‘01-Nov. ‘02
NH 5.6 (N=83) 3.8 (N=55) 5.3 (N=77)
US 6.6 (N=27,100) 6.7 (N=27,500) 6.9 (N=27,700)

The 2003 LBW rate, at 6.2%, remained lower than the US non-Hispanic white rate of 7.0%. LBW remains higher for the Medicaid population, at 7.2%, than for the privately insured (6.0%). The percent of women receiving late or no prenatal care in 2003 was 1.1% compared to the US non-Hispanic white rate of 2.1%. However, the percent of women on Medicaid receiving adequate prenatal care (> 80% observed to expected prenatal care ratio on the Kotelchuck Index) remains below that of non-Medicaid women (86.8% versus 91.7%) and may explain, in part, disparities in LBW and infant mortality.(23)

SOCIOECONOMIC INDICATORS

INDUSTRY & INCOME: New Hampshire's economic profile is largely one of prosperity as we follow the national trend of shifting from a goods producing economy toward a service providing one. For example, New Hampshire's Gross State Product grew 2nd fastest in the region and 16th fastest in the nation and the average weekly wage increased at the same rate as inflation from 2000 to 2003. In 2003, New Hampshire's average weekly wage was $718, slightly lower than the national figure of $726, and our median household income ranked first in the nation, along with New Jersey, Maryland, Alaska, Connecticut, and Minnesota.(24)

UNEMPLOYMENT & POVERTY: New Hampshire continue its recovery from the 2001 recession with the number of unemployed people decreasing during 2003, breaking a three-year trend of increases and yielding a fifth-lowest-in-the-nation average unemployment rate of 4.3%. However, New Hampshire ranked 40th in the nation for unemployment duration during the same year, with an average unemployment duration of 17.8 weeks. In addition, bankruptcy filings increased to a record high of 4,357 in 2003, up 8.4% from 2002.(25) New Hampshire's preliminary seasonally adjusted unemployment rate for 2005 is 3.7% and continues to be lower than the US rate of 5.2%. (26)

Many New Hampshire families and children live below the federal poverty level. Between 1990 and 2000, the proportion of NH children in poverty increased from 7.4% to 7.8%, while the nationwide proportion decreased from 18.3% to 16.6%.(27) Poverty rates for New Hampshire indicate that in 2003, 8% of people were in poverty. Eight percent of related children under 18 were below the poverty level, compared with 9 percent of people 65 years old and over. Five percent of all families and 19% of families with a female householder and no husband present had incomes below the poverty level. (28) In 2003, an estimated 5.1% of New Hampshire families had incomes below the federal poverty level compared to the US average of 9.8%. However, this percentage has increased significantly from the 2000 figure of 3.5%.(29) This signifies a disquieting trend for our state's children, as the negative impact of poverty on the health and well being of children is well documented.

SSI RECIPIENTS: New Hampshire is a SS209(b) state where eligibility for SSI does not automatically qualify a child for Medicaid benefits. As of December 2003, the number of New Hampshire children receiving SSI cash benefits for their own disability was 1710, a 5% increase over the 1,630 reported in December of 2000. (30) These children constitute 13.4% of all SSI recipients in the state, which is congruent with the 2003 national rate of 13.8% for children under age 18. (31) Based on a recent NH survey, 67% of NH children receiving SSI for their own disability were enrolled in Medicaid in 2004. (32)

SOCIOECONOMIC HEALTH CONCERNS: While many of New Hampshire's health and economic indicators are impressive, there are tremendous disparities within the state. Kids Count New Hampshire 2003 reports data related to children and families, grouping towns into five economic clusters ranging from poor to wealthy, and exploring how child health varies by residence. Dramatic differences exist among communities, even for indicators where the state as a whole excels. For example, inadequate prenatal care rates are 2 to 3 times higher in the poorest communities than the wealthiest. Teen birth rates are 3.5 times greater in the poorest communities than the wealthiest. In the wealthiest towns, 1 in 9 births are to single mothers versus 1 in 3 births to single mothers in the poorest towns. (33)

HOUSING: In 2003, median monthly housing costs were $1,420 for mortgage owners, $493 for non-mortgage owners, and $780 for renters. Twenty-eight percent of owners with mortgages, 19% of owners without mortgages, and 45% of renters spent 30% or more of household income on housing. (34) From 1999 to 2004, median gross rental costs increased from 19%, in the most northern, rural areas, to over 35%, in the central part of the state. For 2004, the two bedroom median gross rent including utilities was $978 per month. (35)

HEALTH INSURANCE STATUS: The US Census Bureau estimates that about 131,000 people in New Hampshire were uninsured in 2003. (36) According to National Survey of CSHCN data for New Hampshire, 6% of CSHCN were uninsured at the time of interview. Of those insured, 22% were enrolled in public insurance and 6% in a combination of public/private.(37)

In 2001, the New Hampshire Insurance Family Survey estimated the number of uninsured and explore reasons for uninsurance. The random telephone survey interviewed 5,177 adult (age 18-64) family health care decision makers. The percent of uninsured children was estimated to be 5.1 (16,000 children), compared with the 8.3% (26,000 children) in a 1999 survey. (38) In the New Hampshire state profile from the Data Research Center for Children and Youth Special Health Care Needs (CYSHCN) (Indicator 3), 14.5% of CYSHCN were reported to be without insurance at some point during the past year (pre-survey), while 94.1% were insured at the time of the interview (Indicator 4). (39) Almost 9% of NH youth with special health care needs between ages 12-17 were without insurance at the time of the survey and 17% of this age group was uninsured at some point during the preceding 12 months. (Indicator 4)

The highest uninsurance rates in New Hampshire are among young adults ages 18 through 29 (14%) followed by those 30-44 years of age (10%). It is estimated that nearly 75% of uninsured women in the state are of childbearing age. An estimated 30% of all uninsured women were ages 18-29 and 43% were ages 30-44. Half of these uninsured women ages 18-44 are not Medicaid eligible. Thus, large numbers of women may have difficulty accessing reproductive or perinatal care due to lack of health insurance. (40)

MEDICAID & SCHIP: New Hampshire's CHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Healthy Kids Gold (HKG -Medicaid) expands coverage for infants up to 300% of federal poverty level (FPL). Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income.

In New Hampshire, pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. In 2003, Medicaid was the payment source for 20.3% of all births in the state. (HSDM) Of women obtaining prenatal care through Title V funded agencies, 69% were enrolled in Medicaid in 2003 and 12% were uninsured, 13% were between 15 and 19 years of age, and 43.5% were between 20 and 24 years of age. (MCH) These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

NHHK estimates that, in its first 15 months of operation, CHIP reduced the number of uninsured children by one-third.(41) The 2001Insurance Family Survey estimated that the 32,928 children enrolled in NHHK represent 68.5% of eligible children targeted for the program, leaving 31.5% of those eligible uninsured. Healthy Kids Gold reported 60,909 enrollees as of March 2005. Healthy Kids Silver had 8,209 children enrolled, including those in the self-pay program. (42)

A recent survey of Healthy Kids participants revealed that families are disenrolling at rates lower than other states. Those surveyed believed the application was easy to understand and reported satisfaction with health access and care, with few reporting unmet health care needs. Some differences were found between those with Healthy Kids Silver and Healthy Kids Gold relative to ease of access to care and compliance with preventive visits, with the former reporting higher percentages. This evaluation will inform NHHK to make necessary programmatic adjustments. Efforts continue to

ascertain why eligible children are not enrolled. Some reasons include: inability to pay premiums; lack of understanding of eligibility; belief that insurance is unnecessary as basic medical services can be accessed through safety net providers; and difficulties associated with eligibility determination and enrollment procedures. Efforts are underway to streamline eligibility determination and continue outreach, exploring creative options to encourage enrollment. (43)

STATE ISSUES IMPACTING WOMEN & CHILDREN

MEDICAID MODERNIZATION: Like other states, New Hampshire is grappling with Medicaid costs, and working to devise a more efficient and effective system of health coverage for eligible populations. This initiative, known as Granite Care, promises to bring significant changes to eligibility and covered services over the next years. While still in the planning stages, proposed reforms have included expanded eligibility for pregnant women and reproductive health services, institution of health services accounts for pregnant women and children, and the development of systems to improve community-based care for senior citizens.

TANF REAUTHORIZATION & CHILD CARE: Two issues impacting the health of women and children in New Hampshire are welfare reform and child care. The annual average number of Temporary Assistance to Needy Families (TANF) cases open on the last day of the month has declined 34% from 1994 to 2004 from 9,071 to 5,932.(44) As of August, 2004, 771 people had reached their 60-month time limit on TANF. (45) An estimated average of 21 individuals will reach this limit each month during the coming year. (46) MCH is aware of the importance of reaching out to this population to assure access to health care.

The number and percent of children receiving TANF assistance has also declined, with marked differences among the town economic clusters described earlier. Wealthier communities saw a decline of 45% during 1995-1999, while poorer ones saw a decline of only 33%.(43) The number of children in poorer cluster of towns receiving food stamps and Medicaid benefits is 4 to 5 times that of the wealthiest cluster. (47)

If TANF is to be successful in moving women into the workforce, then available quality child care with an adequate capacity to serve all children in need is paramount. A 1997 report estimated that 56% of preschoolers requiring out of home care were in regulated child care settings, leaving the remainder in unregulated settings or without care at all.(48) As of September 2002, an average of 14.3 licensed child care opportunities existed per 100 children age 0-17.(49)

In 2003, 64.9% of NH women participated in the labor force, seventh in the nation for this indicator. (50) This figure is likely to increase as TANF rolls decline. New work requirements will result in a burgeoning demand for quality child care and an increased need to support child care providers in the areas of health and safety and early childhood development. MCH's Healthy Child Care NH initiative is working to improve a key component of quality child care, health and safety in child care environments.

Parents of CSHCN receiving TANF, Medicaid, and/or SSI for a disabled child are among the hardest to assist through many traditional mechanisms. Sustaining employment and accessing appropriate, adequate child care for children with special needs are often impossible conditions for these parents to meet. A 2002 government report on welfare reform found that 15% of TANF recipients were adults who reported having at least one physical or mental impairment and a child who also had impairment, or were parents caring for a child with a disability. (51) It is estimated that up to 40% of women with welfare experience have children with special health care needs. (52) Welfare parents with children with special needs are 33% more likely to lose a job involuntarily, due to the effects of the child's chronic illness. (53) A 2002 Manpower Demonstration Research Corporation study found that 25% of non-employed mothers receiving TANF had a child with an illness or disability that limited her ability to work or attend school. (54)

HOMELESSNESS: One in ten poor children, over 1 million children in the US, experience

homelessness every year; the risk is higher for younger children. Homelessness greatly impacts the health and well being of children and youth. Compared to children with homes, homeless children are more likely to have health problems, developmental delays, mental health problems such as anxiety and depression, behavioral problems and lower academic achievement.

As much as 12% of the homeless population is estimated to consist of youth between the ages of 16 and 24 years old who are not living in families. Homelessness creates enormous negative health and social costs for young people, These youth have high poverty rates and are often runaways or throwaways who have experienced physical and/or sexual abuse, childhood homelessness, parental substance abuse, foster care and/or juvenile detention. It is estimated that 25% of foster children have experienced homelessness within 2 to 4 years of leaving foster care. Homeless youth have an increased risk of physical and sexual abuse on the streets and in adult homeless shelters, with sexual assault rates of homeless youth estimated at 15 to 20 percent and physical assault at 50%.

Obtaining accurate data on homelessness is challenging; these data often undercount the true population. A one-day count of students in homeless situations in January 2005 identified 976 homeless students in New Hampshire, 0.5% of students attending NH public schools in 2002-2003 (most recent available data). (55) Homeless NH families often live in seasonal rentals, moving several times per year between campgrounds in the summer and motels and apartments in the winter. Children in these settings are often forced to leave school in the spring when they are must leave a winter rental before the school year ends, disrupting their education and social networks.

CURRENT STATE HEALTH AGENCY PRIORITIES & THE IMPACT ON TITLE V

NEWBORN SCREENING: Scientific advances have resulted in the ability to screen newborns for a multitude of heritable disorders. In 2002, New Hampshire formed a Newborn Screening Program Advisory Committee (NSPAC) to consider this issue and make recommendations for screening, focusing on the then-current March of Dimes recommendation to screen for 10 disorders. The NSPAC recommended in late 2003 to increase New Hampshire's panel to 10 disorders. In response, the DHHS examined the current funding mechanism of the program and determined that an amendment to the statute was needed to add the recommended screenings and keep abreast of the rapidly changing science in this field. Senate Bill 108, introduced in the fall of 2004, would accomplish both of these goals. While this bill sailed smoothly through the Senate approval process, media attention nearly resulted in retention in the House. At this point, it is expected that the bill will pass. The NSPAC continues to meet, next considering recommendations contained in the recently released ACMG report.

REFUGEE HEALTH: Refugee health became a noteworthy issue and important DHHS priority this year, as a cluster of refugee children with elevated lead levels occurred during the summer and fall of 2004 in Manchester. Since the death of a refugee child from lead poisoning in 2002, New Hampshire has obtained baseline and follow up lead levels on refugee children resettled in the state. MCH's CLPPP worked with the CDC's Lead Program, the state's EIS Officer, the Manchester Health Department and the Refugee Resettlement Agencies to develop a coordinated response to this issue. The completion of a descriptive case series investigation of this cluster, published in the MMWR in October 2004, concluded that lead poisoning occurred after resettlement in New Hampshire and therefore a follow up lead screen of refugees three to six months after the initial screen on arrival is useful. A cohort study, described further in Section IVB, is currently underway to examine potential risk factors among refugee and non-refugee children living in comparable housing in Manchester. This investigation resulted in new recommendations from CDC on lead screening in refugee populations, and emphasized the need for New Hampshire to proactively consider the health needs of its refugee population.

PERFORMANCE MANAGEMENT: Performance management is a key DHHS strategy for improving state and local capacity to deliver core public health services and increase service quality. Our vision is to promote evidence-based practice by defining and measuring quality; establishing quantitative performance expectations; and holding state and local health systems, community agencies, and

other service providers accountable through performance-based contracting. DHHS reorganization in 2004 created a new Bureau of Policy and Performance Management (BPPM) within the public health agency to work toward this goal for both internal and external processes. Trainings held in February 2003 and April 2005 taught performance measure development to program managers throughout the Division of Public Health Services (DPHS). Performance measure targets for community agencies are monitored over time and used in specialized Performance Management site visits to assist agencies in improving processes and outcomes. A DPHS Continuous Quality Improvement Committee will form this year, co-chaired by the BPPM Bureau Chief and the Title V Director.

Special Medical Services is in the process of updating and revising policy and procedure for quality assurance and improvement, and has increased the requirements for contractors to meet specified performance measures, congruent with the national measures for CSHCN. The Neuromotor Programs are focusing on evidence-based practices, e.g. regarding pain management and spasticity control. Special attention will be given to patient and family satisfaction measures during the next fiscal year.

HEALTHY PEOPLE 2010: DHHS used the Healthy People 2010 process to establish the state's prevention agenda. MCH staff was actively involved in and remains committed to aligning MCH program goals with leading health status indicators as articulated in Healthy NH 2010. MCH staff led Healthy NH 2010 work groups for Maternal, Infant and Child, Reproductive and Sexual Health, and Injury Prevention focus areas to select indicators for New Hampshire and create action plans for these objectives. These objectives are included in the attachment to this section. MCH and SMS use the Healthy NH 2010 objectives, along with Title V Performance Measures and other national and state objectives, to guide and measure their efforts. For example, pertinent Healthy NH 2010 objectives are integrated throughout the NH Adolescent Health Strategic Plan released this year. In addition, Healthy NH 2010 objectives and Title V performance measures are used where applicable with contracted community agencies providing MCH services. These performance measures are the basis of DPHS' work toward the implementation of performance management into public health practice. See Section IVB for MCH activities in this area.

STRENGTHENING THE SAFETY NET: Another top DHHS priority is to preserve and strengthen our infrastructure of community agencies serving low income and uninsured populations. Like all states, we have evolved a patchwork of health centers and other local agencies providing direct and enabling services. These agencies successfully integrate public health and prevention into clinical practice, providing true population-based care and leveraging far more in services than what is paid for by public funds. Their survival is critical to the continuing health of our communities.

A 2000 report affirmed that the Community Health Centers (CHCs) are essential health care system components that serve individuals who may otherwise not be able to access health care and called for a renewed public and private commitment to CHCs. The report clearly described the deteriorating financial status of these agencies. Recommendations included: Medicaid and CHIP enrollment for all eligible patients; continued efforts to expand private health insurance; maximizing federal funding by expanding the number of 330 centers; examining DHHS resource allocations and reimbursement for certain services; expanding partnerships with hospitals, businesses and foundations; and securing access to long-term funding and short-term credit. (56)

The state's CHCs saw 24,055 uninsured patients in 2004, over 18% of all the uninsured in the state. (57) While 11% of the state's residents were uninsured in 2003, 32% of CHC patients were uninsured. Similarly, 21% of CHC clients were enrolled in Medicaid while about 6% of the state's residents were Medicaid eligible. (58) State CHCs are funded in part through Title V. The FY2006 State budget preserves current CHC funding, including a 2004 increase of $1.1 million that provided a much needed influx of funding to help sustain these safety net providers.

ENHANCED PUBLIC HEALTH BENEFITS FOR MEDICAID RECIPIENTS: Title V partners with Medicaid to expand MCH services such as home visiting, enhanced prenatal care, substance abuse treatment and oral health care. For example, in 2004, a local Medicaid code was developed that

allows reimbursement to MCH contract agencies for family support and coordination services. MCH and Medicaid coordinate in the quality assurance and training activities for this code.

Pharmacy Benefits Management was implemented in November 2001 for individuals receiving prescription medications through Medicaid. This program should reduce Medicaid drug expenditures while improving quality control and data reporting capabilities and claims. Medicaid is currently implementing a comprehensive disease management program for recipients with respiratory, heart and kidney disease, and diabetes mellitus. This program will promote adherence to health care treatment plans and evidence based guidelines through individualized counseling with trained specialty care nurses, with the goals of: enhancing health status and quality of life; reducing barriers to care; improving communication with health care providers; improving symptom identification and control; increasing medication compliance; and increasing understanding of the use of medical homes.

THE POLITICAL CLIMATE

New Hampshire operates under a unique Governor & Council (G&C) form of government. Five Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. The Councilors participate in the active management of the business of the state. Together, the G&C has the authority and responsibility over the administration of the affairs of the state as defined in the New Hampshire Constitution, its' statutes and the advisory opinions of the New Hampshire Supreme Court and the Attorney General. All state departments and agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of $5,000 or more. New Hampshire also has the third largest legislative body in the English-speaking world, consisting of 24 senators and 400 representatives. The structure and size of New Hampshire's executive and legislative branches, respectively, ensure that citizens are well represented in matters of the state.

In January 2005, democratic Governor John Lynch took office, while a republican majority remained in the legislature. Governor Lynch is working to make progress on the issues important to NH families -- education, health care costs, the environment, and employment. Commissioner John Stephen, former Assistant Commissioner of Safety, was appointed in the fall of 2003. Under Commissioner Stephen, DHHS is completing extensive restructuring, to bring programs into alignment and promote efficiencies within the department.

THE STATE BUDGET & SCHOOL FUNDING: The biennium budget process for SFY06/07 has brought continued fiscal challenges to both the state and DHHS, as New Hampshire strives to achieve a balanced budget. A significant issue impacting New Hampshire's budget considerations for the past decade has been funding for public education. Developing an equitable school funding methodology, and finding state funds to pay for an adequate public education for every child has impacted the state's ability to address some other issues. At this point, the budget maintains funding for most essential MCH services. A mechanism to fund additional screening for heritable disorders in newborns is included.

ADVOCACY FOR CHILDREN: The Children's Alliance of New Hampshire (CANH), the child advocacy group that annually produces Kids Count New Hampshire, also publishes an annual plan to focus attention on and build support for children's needs, the Children's Agenda. Both Kids Count and the Children's Agenda set forth priorities for public policy and identify gaps in available data that are needed to adequately describe and monitor the status of children and families in the state. These efforts place a high priority on children and families, promoting a climate ripe for collaboration among many stakeholders to work towards improving the health of children in New Hampshire. Both MCH and SMS are members of CANH and participate in setting the annual Agenda.

STATEWIDE HEALTH CARE DELIVERY SYSTEMS

New Hampshire's health care delivery system consists of an array of public and private health service

providers. This system, which is varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens that is the New Hampshire Department of Health and Human Services' (DHHS) vision. Much of the state is designated as medically underserved. While New Hampshire's two largest cities have public health departments, there is no statewide network of local health departments providing direct or population based health care services. Instead, the DHHS contracts with community-based, non-profit, safety net providers such as community health centers, prenatal, family planning, and child health agencies. These agencies provide direct health care and enabling services, such as case management, care coordination, nutrition, social services, home visiting, transportation, and translation to low income, uninsured and underinsured populations including those with special health care needs. Their locations assure that most services are available throughout the state. This patchwork of agencies, along with private providers and specialty clinics for those with special health care needs, comprises the State's primary care health care service system. Maps of health shortage areas and a list of MCH contract agencies are attached to this section.

PUBLIC HEALTH INFRASTRUCTURE: The bastion of New Hampshire's public health infrastructure is the DHHS. The Division of Public Health Services (DPHS), as the public health arm of DHHS, promotes the development of public health infrastructure and capacity in various ways, including funding community agencies to provide direct health care services, developing community and state level health programs, and imparting leadership and direction through health policy and planning activities.

The Community Public Health Development Program is dedicated to building New Hampshire's local public health systems. This program promotes regional collaborations to ensure that the ten essential public health services are provided and that local public health systems are fully integrated with local emergency preparedness and response systems and the state public health system. Grantees are responsible for developing strategic linkages with businesses, schools, hospitals, and human service providers to assess and plan for improvement of overall health status and to participate, when necessary, in local public health related emergency response. As emergency preparedness capacity is achieved, the PHNs will also provide an umbrella for convening and coordinating other local public health-focused coalitions and networks.

HIGH RISK NEWBORN FACILITIES: New Hampshire has 24 birthing hospitals, a decrease from 26 birthing hospitals in 2003. Dartmouth Hitchcock Medical Center (DHMC) in the western central part of the state provides tertiary care in most specialties for much of the state. This and the Elliot Hospital in southern New Hampshire are the in-state alternatives for high-risk newborn care. In some areas, patients may seek specialty or tertiary care in Massachusetts or Maine, but most high-risk births are delivered at DMHC. DHMC administers a regional perinatal outreach program and conducts transport conferences with state birthing hospitals to monitor the appropriateness of transfers of high-risk mothers and infants to the facility. The perinatal program also provides continuing education to hospital perinatal nurse managers.

MENTAL HEALTH SERVICES: A continuing gap in New Hampshire's health care infrastructure is access to mental health services. Although Medicaid covers mental health services, services are difficult to access. While community mental health centers are available in some regions, they cannot meet the demand for services. In addition, in selected areas of the state it is proposed that services for the developmentally disabled (Area Agencies) be combined with community mental health centers. All centers have waiting lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for very young children.

According to the Data Research Center for CYSHCN, in 2001 32.7% of NH children with special health care needs needed mental health or counseling services at some time during the year preceding the survey. Of children needing these services, 15.3% of families reported not receiving the service. (59) The 2004 NH survey of CSHCN receiving SSI for their own disability indicated that 51% of that group needed mental health care, but 28% of those needing mental health care did not receive

the services. See the NH CSHCN SSI report in the Needs Assessment.

The Division of Behavioral Health (DBH) and the NH Infant Mental Health Association are addressing these issues. The community mental health system for children has been developing a more complete service array in each region to better meet local need, but resources remain inadequate. The DBH has undertaken a comprehensive examination of financing and is committed to shifting resources to the children's mental health system. In collaboration with DHHS and DOE, DBH is working to increase access to mental health services for children birth through six and their families. SMS is planning an initative for the workforce development of respite and child care providers for the families of behaviorally and medically complex CSHCN.

ORAL HEALTH SERVICES: Improving access to oral health services for vulnerable populations continues to be a high priority for DHHS, but barriers to realizing this goal persist. The distribution of dentists throughout the state is erratic and few treat uninsured and underinsured clients. For example, there are only 21 pediatric dentists in the state, located primarily in central and southern regions; the rural North Country has no pediatric dentists. In the North Country, the overall dentist to patient ratio is 1:4,338, 30% of the population fall under 200% FPL, and only 12% benefit from optimal water fluoridation. (60) One urban and four rural New Hampshire areas are designated as Dental Health Professional Shortage areas; together, these areas contain 20% of the state's population. In addition, the dental work force is aging. Of the 675 dentists practicing in the state, 44% are over age 50. The number of new dentists moving to New Hampshire will be insufficient to replace those retiring in coming years; without a state dental school, there is no local supply of newly trained dentists to fill the need.

Data from NH's 2003 oral health statewide survey of third grade students revealed that 22% had untreated decay, 52% had caries experience and 46% had sealants on at least one permanent molar. Among those same children 25% needed early dental care, and 5% required urgent dental treatment. (61) Similarly, the 2001 National Survey of CSHCN indicated that, while 83.5% of New Hampshire's CSHCN needed dental care, including check-ups, in the 12 months preceding the survey, approximately 9% did not receive all the dental care needed. (62)

Since 2001, numerous improvements in the Medicaid oral health system have been realized, including increased reimbursements, streamlined claims processing, the elimination of prior authorization, improved provider relations and utilization review.
Through the PHHS Block Grant, the DHHS funds school-based preventive programs and community dental centers. In addition, five agencies across the state have DHHS contracts to provide dental operatories on behalf of children receiving Medicaid: Avis Goodwin Community Health Center in Dover/Rochester; Greater Nashua Dental Connection in Nashua; North Country Health Consortium, with mobile services in 6 towns; Poisson Dental Clinic; and White Mountain Community Health Center in Conway.

EVALUATING HEALTH SYSTEMS FACTORS & DEVELOPING TITLE V PRIORITIES

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. Emerging issues for CSHCN have been identified, validated and assessed, via an extensive Delphi process, and the results have been incorporated into the State priorities.
CSHCN priorities are based on the SMS needs assessment, focus group data, parent advisory input, and the National Survey of Children with Special Health Care Needs 2001 results for New Hampshire. One new priority need, respite and child care workforce development, has been selected to be addressed in FY06. SMS and MCH are also jointly addressing the identified priorities of mental health services for children and adolescents, and the issue of child and adolescent overweight/obesity.

Key Title V managers annually evaluate these factors as they relate to the Title V mission, needs assessment findings and Health Systems Capacity Indicators data to arrive at consensus on state priority needs. A detailed description of this process is discussed in Section II; the list of Title V

priorities for this year can be found in Section IVB.

Endnotes are attached to this Section.

B. AGENCY CAPACITY

STATEWIDE SYSTEM FOR CSHCN

For children with special health care needs (CSHCN) an interdependent relationship exists between the private medical system and the Title V CSHCN Program. Private practice pediatricians and family practitioners provide primary care for the large majority of New Hampshire's CSHCN and are the foundation of the state's primary care infrastructure. However, physician distribution is uneven across the state. Of concern is the availability of pediatricians to care for this population of children.

Dartmouth Hitchcock Medical Center (DHMC) in Lebanon provides tertiary care for CSHCN through "ChaD", the Children's Hospital at Dartmouth. Inpatient units include the Intensive Care Nursery, Pediatric Intensive Care Unit and Pediatric and Adolescent Inpatient Unit. Specialty clinics for cystic fibrosis, spina bifida, cardiac anomalies, cleft lip and palate, epilepsy and child development are held at ChaD. The DHMC Child Development Clinic is supported by contract and SMS provides a multidisciplinary neuromotor clinic at ChaD, as part of our statewide Neuromotor Program. Clinical nurse coordinators are part of the sub-specialty teams at ChaD and interagency referrals between occur on a regular basis.

An important addition to services at DHMC is the ChaD Family Center that provides health information, access to financial assistance and a quiet place to relax between visits. A unique support and educational program offered at the medical center is the Steps Toward Adult Responsibility (STAR) Program for teenagers living with chronic, physical health conditions.

In addition to Lebanon, pediatric sub-specialty services are offered in Manchester, a more central location, and Child Development, cardiology and neurology services are available statewide at other locations.

Ninety-seven percent of NH respondents to the National CSHCN survey said they received the specialty care that their child needed. However, information received from the Board of Medicine, supported by clinician reports, indicates that NH continues to experience a serious shortage of pediatric ophthalmologists, allergists, and physiatrists.

For CSHCN, dental access issues are compounded. Like all children, CSHCN need routine dental care; however access to care is an even larger issue due to the lack of providers who have the skill level necessary to manage this group of children. According to the NSCSHCN, 2001, 42% of NH families said there was a problem with their health plan regarding dental care; 6% said dental care cost too much and 6% said the dentist did not know how to treat CSHCN.

Facilitating and supporting the primary care provider role is an important responsibility of SMS. New Hampshire initiatives related to spreading the concept of the Medical Home are crucial to supporting private practitioners. To date eight pediatric practices have participated in MCHB funded activities associated with the Rural Medical Home, nine practices have participated in the Partners in Chronic Care Project and five practices are currently participating in Beyond the Medical Home activities. SMS supports a 0.5 FTE Public Health Nurse coordinator to work with the Center for Medical Home Improvement. Consultation is provided to care coordinators and office personnel associated with all the sites. An SMS funded parent consultant is an important participant in the Partners in Chronic Care Project. A new SMS initiative, the NH Health Transition Project, is providing intensive collaboration to three pairs of pediatric-adult care providers, to explore the process and strategies involved with moving YSHCN to adult systems of care.

One serious gap in the infrastructure for CSHCN in NH is access to mental health services. Available providers are overburdened. Expertise in treating children and adolescents, in particular CSHCN, is limited in the publicly funded mental health system and few other mental health resources are available to low income and uninsured families. The need to address pediatric mental health issues has been recognized. The New Hampshire Developmental Services Bureau partially supports the salary of a child psychiatrist housed at DHMC whose expertise is management of children and adults with autism, mental retardation and severe emotional disturbance. The New Hampshire Pediatric Society and the Divisions of Psychiatry and Child Development at DHMC are currently piloting new consultation models.

The New Hampshire Behavioral Health Bureau is completing a $5 million, 5 year grant (SAMSHA/New Hampshire Cares) to implement systems of care for children with serious emotional disturbances in three communities. The Title V CSHCN Program has joined with four other State programs to support 14 regional Infant Mental Health teams. These teams are charged with developing community-based, wrap-around services for the 0-5 year population and their families.

Historically and at the current time, it is difficult for parents to obtain independent school consultations from private mental health practitioners or community mental health centers because of minimal support from public or private insurance. These consultations are necessary to deal with diagnostic issues and development of an IEP. While SMS-funded Child Development Programs and the SMS Consulting Psychologist provide some support for school consultations, these services remain extremely under-funded with respect to demand.

CSHCN depend upon the availability of a wide range of services for their health and ability to function. The diversity in conditions and unique needs of CSHCN present an enormous challenge to developing systematic approaches for providing care. The State service delivery system is a patchwork of different systems, including health, education, social/welfare and juvenile justice. Leadership and administration varies across systems and a variety of disease- and issue-specific advisory boards exist at state, regional and local levels. Federal and state mandates defining authority and responsibilities for certain groups of CSHCN are broad and often overlap.

Federal funding received by State agencies further defines programs and services, most often categorically. For example, the New Hampshire Area Agency system consists of 12 designated non-profit and specialized service agencies, which represent specific geographic regions, that have the responsibility of providing information and a wide range of supports and services for NH consumers with developmental disabilities and acquired brain disorders.

NH Partners In Health (PIH) is another important component of the statewide system for CSHCN. This community-based program addresses the needs of families of children with chronic health conditions, birth to age 21, utilizing a family-centered approach and works within the community to facilitate and enhance the care and services that families need. The goal is to create opportunities for families, health professionals and relevant agencies and institutions to work together in order to design innovative solutions that will meet the needs of families within their communities. Flexible funds are available to families participating in the program. SMS coordinators frequently partner with PIH to deliver services to families of CSHCN.

The complexity of the community-level system increases proportionately with the number of agencies, providers and funding sources that are involved. The task of integrating services is a complex undertaking for professionals and families alike. To ensure integration, facilitate this process, and promote family-centered, community-based care, a major portion of SMS resources are used to support professional care coordination services. A centralized staff for specific geographic areas and through contracts with community agencies for high-density urban populations is maintained to support this process.

NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO TITLE V

RSA 125, General Provisions, describes the responsibilities of the Department of Health and Human Services' (DHHS) Commissioner to "take cognizance of the interests of health and life among the people". RSA 126 establishes the DHHS to "provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well being" of New Hampshire citizens and mandates that services "shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens".

RSA 132, Protection for Maternity and Infancy, provides broad authority for MCH and CSHCN services "to protect and promote the physical health of women in their childbearing years and their infants and children". It authorizes the Commissioner to: accept federal funds; employ staff; cooperate with federal, state and local agencies to plan and provide services; supervise contracts with local agencies; make rules and to conduct studies as necessary to carry out the provisions of the law. CSHCN services are defined in the law as diagnoses, hospitalization, medical, surgical corrective and other services and care of such children. This law also allows for administration of the WIC program.

RSA 132-A creates an exemption to child abandonment laws if the child is delivered to a "safe haven".

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders.

RSA 132:24 requires parental notification before abortions may be performed on unemancipated minors.

RSA 611, Medical Examiners, requires the medical examiner to file a record with MCH of any death determined to be the result of Sudden Infant Death Syndrome.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury or cystic fibrosis, which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by DHHS; eligibility and services to be covered are set forth in rules.

RSA 126 contains provisions establishing a division of juvenile justice services; allowing for DHHS quality assurance activities; establishing an Advisory Council on Child Care to plan for improved child care services, report to the Legislature and Governor, and to act as a forum to receive child care related information; the development of primary preventive health services for low-income and uninsured populations; establishing an emergency shelter program, a council for children and adolescents with chronic health conditions and their families, and the Tobacco Use Prevention Funds; and restricts sale of tobacco products to minors. RSA 126-M:1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

RSA 130-A, Lead Poisoning Prevention and Control, provides for public education, comprehensive case management services, an investigation and enforcement program and the establishment of a database on lead poisoning in children.

RSA 135-C allows DHHS to establish, maintain, and coordinate a comprehensive system of mental health services.

RSA 141-C, Immunization, and Reporting Communicable Diseases, prohibits enrollment in school or child care unless immunization standards are met, requires reporting of specified communicable diseases to the State Department of Public Health, prohibits mandatory genetic testing and requires informed consent, except for establishment of paternity and for newborn metabolic screening.

RSA 169-C mandates reporting of suspected child abuse.

RSA 263:14 outlines a system of graduated licensing for youthful operators.

RSA 265:82 prohibits driving while under the influence of alcohol or drugs and requires the use of infant booster seats and seat belts up to age 18.

RSA5-C:2 establishes the Division of Vital Records within the Department of State.

The full, unofficial text of these statutes may be accessed on the State's website at: www.state.nh.us. Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.

Listed below are bills of particular interest to Title V passed by the New Hampshire Legislature during the most recent Legislative Session.

Senate Bill (SB) 30 establishes the Collaborative Practice for Emergency Contraception Act, allowing a pharmacist to initiate emergency contraception. SB108 addresses adding to the panel of newborn screening tests and creates a restricted revenue fund to cover the cost of the screening laboratory's contract. House Bill (HB) 118 requires bicycle helmet use by persons 16 years of age or less when riding on public ways. HB383 requires the secretary of state and the commissioner of the department of health and human services to enter into a memorandum of understanding relative to the state's vital record system. All of these bills were passed during the 2005 session.

PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, and as outlined in Section IIIA, MCH contracts with community agencies to provide prenatal, reproductive health care, and home visiting services for low income and underserved populations. Thirteen agencies statewide provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and individual social services. Of these, ten are primary care community health centers (CHC), offering the full spectrum of health care services to all ages; the others are ‘categorical', offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds, and 15 agencies provide home visiting services for pregnant women, and mothers and their infants through age one.

Of the ten CHCs, seven have Federally Qualified Health Center status. These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. Two CHC locations are health centers affiliated with hospitals; one center applied for 330 status in 2005, but was not funded. The three categorical prenatal agencies offer care directly or through subcontract with local physicians. By contract, social services, nutritional counseling, and referral for high-risk care must be provided.

In 2003, these 13 agencies served 2107 (14%) of New Hampshire's pregnant women. Of pregnant women served by MCH agencies, 69% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 13% were between 15 and 19 years of age, and 43.5% were between 20 and 24 years of age.

MCH also contracts with 15 community-based agencies in 18 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) is a preventive program that provides health, education, support and linkages to other community services. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are supported in their roles as their child's first and best teacher and learn ways to enhance their child's learning and development.

HVNH served over 700 pregnant women and their infants in SFY04. By funding almost two thirds of program sites in counties with a higher than the state average poverty rates, the program is able reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports embedded within each unique community.

Recent evaluations have shown that 34% of participants come into the home visiting program with a history of depression. During pregnancy, 22% of participants demonstrated symptoms of depression. That rate dropped by half to 11% after the baby was born. Participating women also have high rates of smoking, but during program participation, they reduced the numbers of cigarettes smoked. Specifically, although 63% of women smoked prior to pregnancy, by the time they gave birth that number dropped to 33%. Another compelling result of HVNH evaluations was that over 90% of participants initiated prenatal care at the recommended time and over 95% received the recommended number of prenatal visits, higher than state averages.

Prenatal Disparities: Section IIIA of this application presents data clearly delineating disparities in prenatal care access and health outcomes for privately insured women versus those uninsured or on Medicaid. The 2005 needs assessment provides much information about those groups more likely to obtain less than adequate prenatal care or experience poor pregnancy outcomes. While MCH knows little about where these women obtain prenatal care, other than at its' contract agencies, or whether care meets acceptable OB standards, we recognize the need to further explore these disparities, including examining the private prenatal care system to assure capacity for addressing this population's complex needs. MCH will work with its epidemiologist, Medicaid, WIC, and other stakeholders to develop a plan to address these disparities and any service system gaps.

PREVENTIVE & PRIMARY CARE SERVICES FOR CHILDREN

Title V's capacity for children's preventive and primary care services consists primarily of its network of child health agencies. MCH contracts with 11 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Ten of these are the CHCs described above; one is a ‘categorical' pediatric clinic utilizing a multi-disciplinary care model. Services at child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and, in some cases, mental and oral health services. In 2003, MCH-funded child health direct care agencies saw 12,783 children ages 12 and under, with 19% of their total caseloads enrolled in Medicaid and 57% living at less than 185% of FPL.

In the period from 1996 to 2000 the overall number of clients at MCH categorical agencies, including prenatal, child health and family planning agencies, decreased by 7%, while the number of clients at CHCs increased by 38%. In the case of some categorical child health agencies, enrollment decreased by as much as 68% over this period, presumably due to increasing enrollments in NH Healthy Kids, the state's SCHIP, as well as the growth of the CHCs.

This decline in service utilization led MCH, in 2001, to pilot a model for alternative use of Title V funds for child health services. Recognizing the continued need for low income, often multi-problem families to access support, counseling, and assistance services to effectively access and utilize medical care, local agencies could apply for "Child and Family Health Support" funding in lieu of providing direct care services. Unlike traditional direct care models, Child Health Support funding allowed the use of MCH funds to provide vital enabling services that many families need. A 2003 analysis from CompCare described the need for MCH to continue its' support of community child health agencies. Findings included the perceived benefit of Title V funding at the community level, and the need in some communities to have greater flexibility in the use of funds to meet Title V priorities.

MCH continues to reassess its child health resource allocation to assure that the priority needs of low-

income children and families are met. Each agency applying for enabling service funding is required to demonstrate that direct care services are accessible to vulnerable families in their region. By contract, direct care services such as well child visits and immunizations must be provided by Child Health Support agencies should the need arise during the contract period. For SFY 2006, MCH is piloting grants that allow agencies more flexibility to meet local needs. In addition to providing direct child health services where the need exists, agencies may choose from a menu of additional services, including child and family support services and child care health consultation. In the future, other options for MCH services provided at the local level may be built into local grants. The 2005 Title V needs assessment process will assist MCH in developing additional options for funding local child health services and reassessing resource use and distribution.

All child health agencies providing direct care and all CHCs screen children for developmental delay and refer them to specialty services as appropriate, though the screening tools used vary widely. In 2005, MCH and SMS collaborated with Easter Seals New Hampshire and the New Hampshire Pediatric Society, to apply for a Vermont Child Health Improvement Program grant to expand New Hampshire's successful "Baby Steps" developmental screening project into a 6th Title V funded CHC and a Title V funded community-based support agency. This grant would have developed an "Improvement Partnership" with public and private providers, including the state Medicaid Program, and also revived previous efforts of a NH Pediatric Society workgroup to make recommendations on the use of up-to-date developmental screening tools and trained private medical providers in the new communities where the Baby Steps project will be offered. Though unfunded, Title V will continue to work with these partners to improve developmental screening efforts in the state.

Maps of Prenatal, Family Planning, Home Visiting, and Child Health Service Areas are attached to this Section.

SERVICES FOR CSHCN [Section 505(a)(1)]

CAPACITY TO PROVIDE REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS LESS THAN 16 YEARS OF AGE: NH children under age 18 receiving SSI for their own disability totaled 1710, per SSA 2003 data. Those children under age 16 receiving SSI numbered 1422, per the National Healthy and Ready to Work 2004 data. Children receiving SSI who are clients of SMS number 186, per SMS SFY 05 data, or 13.1% of those under age 16. Special Medical Services assigns a designated care coordinator to follow-up on all children applying for SSI who are not receiving Medicaid and are not included in the SMS client database. See NPM 4 for more detail on SSI follow-up. SMS disseminates periodic, family-friendly, material about SSI and SSI updates applicable to CSHCN and their families. Based on the results of the NH CSHCN SSI survey (see Needs Assessment) SMS is planning to evaluate further the care coordination needs of CSHCN receiving SSI and Medicaid.

The M.I.C.E. (Multi-Sensory Intervention through Consultation and Education) program is administered by the Parent Information Center in cooperation with the Bureau of Developmental Services to serve children (0-3) for whom there is a concern relative to vision and/or hearing. Children may be referred to the Area Agencies for intake and developmental evaluation, in conjunction with Early Supports and Services (ESS) staff. The emphasis is on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance are provided to ESS teams, and direct services to children and families.

CAPACITY TO PROVIDE FAMILY-CENTERED COMMUNITY-BASED, COORDINATED CARE: SMS capacity regarding this element is highlighted throughout most of the SMS-specific service and system descriptions, as well as the Needs Assessment. The Title V CSHCN Program provides a care coordinator for each enrolled child. Following assessment, comprehensive health care plans, responsive to the needs and priorities of the child/family, are developed. Central staff and contractors provide coordination of medical services with other community providers and schools, to ensure continuity of care, and support that will empower families to assume the role of primary coordinator for their child. SMS is currently focusing on developing care coordination in the medical home.

CULTURAL COMPETENCE & THE TITLE V PROGRAM

The rising importance of racial and minority health in New Hampshire is demonstrated by the near doubling of NH minority births between 1997 and 2002. The 2001 Title V needs assessment illustrated that the state's minorities are a heterogeneous group with diverse prenatal health and health care utilization patterns, as traditional associations between marital status, age, education, and LBW were not consistently supported by minority birth data. For example, the highest LBW was found in black college graduates and beyond (11.8%) and the best infant outcomes in American Indians with less than a high school education (2.9%). While the analysis did not explain the cultural and social dimensions of these groups in NH, it confirmed the need to further examine minority issues and proactively plan for addressing their needs.

Title V undertook several activities to garner information on minority populations. Through the SSDI grant, the Manchester Health Department studied health disparities and barriers to access among racial, ethnic and socioeconomic minorities. Focus groups were held with minority women to learn about their experiences in accessing prenatal care. Completed in 2002, focus groups revealed that, while most were satisfied with the prenatal care received, many minority women voiced problems encountered in receiving care. Barriers to prenatal care included lack of insurance, language difficulties, work conflicts, lack of child care, and transportation difficulties.

With the NH Immunization Program, focus groups on child health access issues were held in Manchester and Nashua. The 2005 report revealed that minority participants believed childhood immunizations to be effective and necessary but identified several barriers to accessing health care in these two cities. Barriers included lack of insurance, difficulty navigating the Medicaid system, lack of awareness about available community services, and fear of deportation on the part of undocumented participants. The top challenges in accessing health care by participants were medical interpretation, lack of a central location to access information on available public services, and access to transportation services.

A 2004 study indicated that since 1990 there has been a 22% increase in the population of residents with limited English proficiency (LEP) in NH, most of which reside in Hillsborough County. From 14% to 32% of patients in the county's two largest cities have LEP. Interpreter resources employed by providers include externally paid interpreters, bilingual clinical and non-clinical staff, telephone Language Line use, signage and other written materials, videos, and community-based volunteer resources. Nearly half of LEP discussion group participants incorrectly believed that it was their responsibility to provide or pay for an interpreter. Specific strategies to address such problems are recommended in the report. (Source: Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers, 2004, The Access Project and The Cultural Imperative, funded by the Endowment for Health)

The OMBP provides telephone access in the three languages most spoken by non-native Medicaid consumers, Spanish, Arabic and Bosnian, and all District Offices have mechanisms to facilitate language barrier reduction for their consumers. In SFY03/04, SMS allocated approximately $5000 for interpreter services in contracts with the Child Health Services (CHS) Child Development Program Network, CHS Community Care Coordination of Hillsborough, Rockingham and Strafford Counties Special Needs Children, and the CHS Neuromotor Disabilities Clinical Program. SMS continues to fund interpreters for Child Development and Neuromotor clinics as needed. SMS has translated its application into Spanish, to better serve the state's Latino population.

Title V has become more aware of the challenges facing minorities in NH and current activities to address these issues. The 2004 cluster of elevated lead levels in refugee children provided another reminder that minority concerns are mounting. Over the coming year, MCH hopes to further address minority concerns by working with Refugee Resettlement Agencies on environmental issues, and by exploring mechanisms to address the identified barriers and challenges for minority populations in accessing health care services. One activity will be to bring together the NH Minority Health Coalition,

Title V, and other interested parties to plan for assessing and promoting cultural competence in local agencies using available national standards.

In addition to race/ethnicity and language barriers impacting health care access for some groups, Title V programs are addressing other issues of cultural competence among MCH populations. These include homelessness, mental health/mental disorders, and substance abuse. One issue affecting service availability, accessibility and timely provision, is the lack of comprehensive planning, resource sharing and funding mechanisms, among the state, community-based non-profits, and the private sector. Until recently, health data specific to NH residents was minimal. The MCH and SMS Sections are assessing the new data, to improve health care service and quality, and reduce disparities in health care.

C. ORGANIZATIONAL STRUCTURE

NH's Title V Program is located within the DHHS. The New Hampshire Department of Health and Human Services (DHHS) is headed by a Commissioner reporting directly to the State's Governor. DHHS is currently completing an extensive restructuring. Two major divisions within DHHS are the Division of Public Health Services (DPHS) within the Division of Program Operations and the Office of Medicaid Business and Policy (OMBP).

Administration of the Block Grant is assigned jointly to the Maternal and Child Health Section (MCH) for services to women, infants and children and the Special Medical Services Section (SMS) for children with special health care needs (CSHCN). MCH resides in the DPHS Bureau of Community Health Services (BCHS), along with the Alcohol, Tobacco and Other Drug Treatment Services, HIV/STD Prevention, Rural Health & Primary Care, and Community Health Development.

SMS resides in the OMBP Bureau of Medical Services. This alignment with Medicaid allows SMS to focus on the shared goals of ensuring the adequacy of health insurance for CSHCN, including medical homes, program design, and applied research. The integration within Medicaid operations enhances policy development, disease case management, quality assurance, leadership opportunities for SMS staff, increased access and improved care for CSHCN in New Hampshire, and better access to data systems. Organizational charts are included as an attachment to this section.

Each Title V Program Director (MCH and SMS) is responsible for her own staff, budget, and assuring that activities proposed under the MCH Block Grant are carried out. The MCH Director assumes coordinating responsibilities for the Block Grant submission.

While each program is distinct administratively, they coordinate frequently at the programmatic level. For example, MCH oversees operations of the Newborn Screening Program. If, however, a child is found to have a heritable disorder, MCH staff works with the SMS staff that will provide care coordination services for the child and family. Further, MCH and SMS staff members sit on one another's respective advisory boards as appropriate, such as the Newborn Screening Program Advisory Committee and Preschool Vision and Hearing Program Advisory Committee. Finally, MCH and SMS staff continue to work together with the NH Child Health Month Coalition to develop the packet of health and safety materials mailed to over 5,000 health care providers, child care staff and schools in observance of October as Child Health Month. Such activities assure that the needs of both MCH and CSHCN populations are considered in program planning. A primary example of joint endeavors and coordinated activities is the recent participation in CAST-V activities to examine overall agency capacity.

THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP: MCH PROGRAMS

PRIMARY CARE PROGRAM: MCH supports ten community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for over 60,000

individuals/year. Many sites offer support and enabling services such as nutrition counseling, case management, transportation and interpretation services.

PRENATAL PROGRAM: Thirteen local MCH-funded agencies provide prenatal care to over 2,100 women/year. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care.

CHILD HEALTH PROGRAM: Nineteen community health agencies receive funding to provide child health services. Of these, eleven offer direct care to low-income children through clinics and home visits; eight provide health and social support services to children and their families. All agencies provide case management, outreach, and SCHIP enrollment assistance, and may use funds to provide child care health consultation.

SIDS PROGRAM: The SIDS program offers information, support and resources to families and care providers of infants suspected to have died of SIDS. Title V staff work with trained SIDS Counselors to provide home visits. Information and training are provided upon request.

NEWBORN SCREENING PROGRAM (NSP): The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for heritable disorders ascertained through dried blood spot testing. NH currently screens for six disorders, and plans to add four additional disorders in the coming year.

PRESCHOOL VISION & HEARING PROGRAM (PSVH): PSVH works with trained community volunteers to provide hearing and vision screening and follow-up for approximately 1,700 preschool children/year, targeting low-income families. This program is currently transitioning, from a direct care model to an infrastructure-building model and will offer technical assistance to communities.

EARLY HEARING DETECTION & INTERVENTION (EHDI): EHDI promotes screening all newborns for hearing loss, and helps assure appropriate follow-up and intervention. In 2003, 91% of all newborns born in NH hospitals were screened for hearing loss.

ADOLESCENT HEALTH PROGRAM: The Adolescent Health Program promotes adolescent-friendly health care through one Teen Clinic and ten CHCs. MCH provides technical assistance regarding adolescent health; participates in population-based activities; and coordinates forums for networking around adolescent issues.

ABSTINENCE EDUCATION PROGRAM: This program seeks to reduce unintended pregnancies among children ages 10-14 years through community agreements to implement abstinence-only curricula.

HOME VISITING NEW HAMPSHIRE (HVNH): HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Eighteen projects currently serve in excess of 650 families/year. Title V staff are involved in training, data collection and evaluation activities.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): HCCNH focuses on comparing state child care regulations with national standards, outreach to enroll children in SCHIP, and increasing the number and expertise of child care health consultants.

INJURY PREVENTION PROGRAM (IPP): The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault & domestic violence, funds the State Injury Prevention Center, and is the liaison with the state's Poison Control Center contractor.

STATE SYSTEMS DEVELOPMENT INITIATIVE (SSDI): SSDI is improving data capacity through

linking data sets with infant birth and death registries. A major goal is to link birth certificate and NSP data to assure all babies are screened.

FAMILY PLANNING PROGRAM (FPP): The FPP provides confidential reproductive health care for low-income women and teens to over 30,000 individuals/year. Ten clinics offer "teen only" services incorporating teen peer educators.

CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP): As proscribed in RSA 130-A, the CLPPP provides for public education, comprehensive case management services for children with elevated lead levels, an investigation and enforcement program and the establishment of a database on lead poisoning.

THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP: SMS PROGRAMS

Federal funding supports a portion of all sixteen SMS contracts. More specifically, these contracts for direct services are supported 68% with New Hampshire general funds and 32% with Federal Block Grant funds. This Federal-State Partnership includes the following programs:

CHILD DEVELOPMENT PROGRAM: The Child Development Services Network is comprised of five Child Development Programs contracted through DHMC and local community health agencies to provide a community-based approach to state-of-the-art diagnostic evaluation services, to children (0-6) suspected of or at risk for altered developmental progress.

PEDIATRIC SPECIALTY CLINICS: SMS operates 6 Pediatric Specialty Clinics for Neuromotor Disabilities. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children to fully participate in care planning. The clinic coordinator and consultant staff are supported by SMS. The team addresses issues of physical therapy, orthopedics, and developmental pediatrics, with access to SMS nutrition and psychology services.

NUTRITION, FEEDING AND SWALLOWING PROGRAM: The SMS Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide. These contractors have developed networks of regional nutritionists, and feeding and swallowing specialists. SMS offers specialized training for all network providers and monitors their quality of care to assure a coordinated, outcome-oriented approach that is family-centered and community-based.

CARE COORDINATION INITIATIVE: Each child/family enrolled in the Title V CSHCN Program has a care coordinator who provides an assessment in order to develop comprehensive health care plans that are responsive to the needs and priorities of the child/family. Central staff and contractors provide coordination of medical services with other community providers and schools, to ensure continuity of care, and support that will empower families to assume the role of primary coordinator for their child.

FAMILY SUPPORT SERVICES: Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support group/organizations, and operates a comprehensive website. The staff are three parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance. Upper Valley Parent to Parent Support Program offers a service matching families of newly diagnosed children with parent mentors, an interactive website, and educational materials suitable for parents and professionals.

PSYCHOLOGY CONSULTATION SERVICES: Psychology services are available to any family regardless of SMS financial eligibility. The psychology consultant provides school, assessment, treatment, and staff consultations; confers with nurse coordinators, provides staff workshops/in-services, and helps problem-solve regarding gaps in pediatric mental health services.

D. OTHER MCH CAPACITY

STAFFING

Staffing
The Maternal and Child Health Section (MCH) is headed by an Administrator, who is the MCH Title V Director and responsible for all MCH activities. MCH employs 27.9 FTEs (fulltime staff equivalents); 12 positions are paid in some part through Title V funds. The three main programmatic units within MCH include: Child Health (Child Health, SIDS, EHDI, NSP, PSVH, HVNH, HCCNH, and ECCS programs -- 6 FTEs); Women's Health (Family Planning, Prenatal, Adolescent Health, Abstinence Education, Injury Prevention and SSDI programs -- 7.6 FTEs); and the Childhood Lead Poisoning Prevention Program (7.8 FTEs). The MCH Data Team consists of those staff with an interest or expertise in data collection, analysis and dissemination; the SSDI Program Planner, Program Evaluation Specialist, Quality Assurance Nurse Consultant, Adolescent Health Coordinator and contractual MCH Epidemiologist all participate in this team. MCH also employs administrative support staff (6.5 FTEs). All MCH staff are centrally located at the DPHS building in Concord, NH.

MCH manages four contracts to provide specific consulting capacity to MCH. These include: OB-GYN and pediatric medical consultants; a consulting audiologist; and an MCH epidemiologist. The audiologist, Mary Jane Sullivan, MA, CCC-A, consults to the EHDI program, bringing experience in pediatric audiology and hospital-based newborn hearing screening programs. MCH epidemiologic support is provided by David LaFlamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health. He devotes three days per week to MCH issues, providing expertise in data analysis and health policy. In addition, MCH houses Melissa Heinen, New Hampshire's health education liaison from the New England Poison Control Center.

The Administrator for the Special Medical Services Section (SMS) is the Director of the State Title V CSHCN program (Bumbalo). SMS employs 14 FTE professional staff and employs 5 FTE administrative support staff. Three FTE staff positions are supported by Title V funds. The SMS contracts with 5 individuals to provide CSHCN expertise and services throughout New Hampshire. SMS employs 36 individuals (via agencies) through contracts.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: MCH

Lisa L. Bujno, MSN, ARNP, Administrator
Ms. Bujno received both BS and MS degrees in nursing from the University of Pennsylvania. She has over 13 years experience in public health, including positions in two community health centers and as a civilian community health nurse for the Department of the Army in Germany. She was a 1997 Fellow of the National Association of Community Health Centers, and has been employed in MCH since 1999. Her particular areas of expertise are prenatal and adolescent health issues, primary care in community health center settings, and systems for quality improvement.

Audrey Knight, MSN, ARNP, Child Health Nurse Consultant
Ms. Knight has a Masters degree in nursing from Yale University and has held the position of MCH Child Health Nurse Consultant since 1986. She is the SIDS program coordinator and manages the Child Health, SIDS, PSVH, NSP and EHDI programs. Ms. Knight has expertise in preventive and primary care for children.

Anita Coll, M.Ed, Prenatal and Adolescent Program Manager
Ms. Coll has over 20 years of experience in women's health, including 15 years in public health settings. She has a Masters degree in education from Cambridge College and is currently working toward a law degree. Ms. Coll manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs. Prior to her employment with MCH, Ms. Coll was the Director of Community

Programs for a regional home care corporation that included MCH-funded prenatal and child health programs.

Patricia Tilley, MS, Home Visiting/HCCNH Program Specialist
Ms. Tilley manages the Home Visiting New Hampshire program and oversees Healthy Child Care New Hampshire and ECCS activities. She has a Masters degree in education from the University of Pennsylvania and has worked in home visiting, and family support since 1995.

Kathy Desilets, BS, Family Planning Program Manager
Ms. Desilets has a Graduate Certificate in Public Health from the Rollins School of Public Health. She has over ten years of experience in public health, with an emphasis on reproductive health, HIV and STDs.

Marie Kiely, MPH, SSDI Program Planner
Ms. Kiely manages the MCH Data Team and has a Masters degree in Public Health from Tufts University. Ms. Kiely has nearly 20 years of experience in public health programs, including previous management of the New Hampshire Injury Prevention Program and Cancer Registry.

Michelle Dembiec, MEd, CLPPP Program Manager
Ms. Dembiec manages the CLPPP program and is a Certified Health Education Specialist. She has a Masters degree in health education and ten years of experience in health education and public health programs.

Beverly McGuire, MS, BSN, Quality Assurance Nurse Consultant
Ms. McGuire has a Masters degree in Health Administration and a Juris Doctorate degree. She was hired in 2004 to measure the quality assurance efforts of the funded local agencies. She has 25 years of experience in community health as the CEO of a VNA and community health center.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: SMS

Judith A. Bumbalo, RN, PhD, Administrator, CSHCN Director
Dr. Bumbalo received her M.S. from Boston University and her Ph.D. from Wayne State University, and has over 25 years of experience working with CSHCN and families. As a faculty member for academic nursing programs at the University of Washington and the University of Wisconsin (Milwaukee), she worked closely with state Title V programs. Dr. Bumbalo is the former Director of a Title V training program for graduate education in nursing at the University of Washington. Prior to joining SMS, she was the Training Director for the MCHB funded LEND program at the University of New Hampshire/Dartmouth Medical Center (1995-1999).

Kathy Higgins Cahill, MS, ARNP, Title V CSHCN Program Specialist.
Ms. Cahill was hired for this position in December 2002. The position focus is on the needs assessment process and special projects. One such special project is Youth Health Care Transition. Ms. Cahill has worked as a part-time staff to SMS for many years, assisting with the formation of the Child Development Program and providing care coordination and clinic management services. Currently, Ms. Cahill is the Project Coordinator for the Youth Health Care Transition Project and consults to several work groups that have youth transition initiatives.

Lee Ustinich, M.S., Title V CSHCN Health Care Financing Specialist
Ms. Ustinich received her M.S. in Allied Health/Rehabilitation Counseling from Virginia Commonwealth University (Medical College of Virginia). She was hired in 2002 to focus on the CSHCN Health Care Financing initiative, infrastructure-building services, and the performance measures. Ms. Ustinich is also the SSI State Liaison. She came to SMS from the Virginia Community Services Board system, where she has over ten years experience in the multi-program management of community-based disability services, primarily the development of specialized, family-centered, substance abuse treatment and HIV/AIDS programs.

PARENTS OF CHILDREN WITH SPECIAL NEEDS

Three parents of children with special health care needs staff New Hampshire Family Voices are supported by Title V funds. Martha-Jean Madison and Terry Ohlson-Martin are Co-Directors of the project and Sylvia Pelletier is the Outreach Coordinator. Martha-Jean is the parent of eight children with disabilities and special health care needs, Terry has a son with disabilities and Sylvia is the parent of two children who are cancer survivors.

STAFFING CHANGES

A statewide hiring freeze continued to hamper agency capacity this past year, but waivers were approved for certain MCH vacancies. As mentioned above, Beverly McGuire was hired for the QA Nurse position in June 2004. Ms. McGuire, former CEO of a Rhode Island VNA and community health center, brings a wealth of expertise to this position. She focuses on clinical quality assurance activities and performance management relating to MCH contract agencies. Chantal Kayitesi, MPH, was hired in January 2005 to fill the Adolescent Health Coordinator position. Ms. Kayitesi graduated from the Boston University School of Public Health with a concentration in Health Services. She has over six years of experience in public health, working mostly in women's health and communicable disease programs. In April 2005, MCH was able to fill a critical vacancy. The Executive Secretary position, which had been vacant for 18 months, was filled by Cheryl Storey. Ms. Storey was previously in a secretarial position within MCH, and will enhance program operations through her organizational skills and attention to detail. Joanne Cudmore was hired in May 2005 to fill the secretarial position left vacant by Ms. Storey's promotion, yielding nearly a full complement of support staff in MCH for the first time in two years.

Elizabeth Collins, BA, RN, was hired in March 2004 as a Public Health Nurse Consultant. She has a BA from Wells College and BSN from the University of Southern Maine. She has experience working in an Intermediate Care Facility for the Mentally Retarded, is ANCC certified in Psychiatric Mental Health Nursing, and participated in the UNH LEND program during 2004-2005.

Kathy Hoerbinger, BS, RN, was hired in November 2004 as a part-time Public Health Nurse Coordinator with responsibilities as the Title V liaison between SMS and the Medical Home Initiaitive. Ms. Hoerbinger has over ten years experience as a community-based care coordinator in New Hampshire.

The position of SMS Program Manager, which oversees the health coordinators, remains vacant and ‘frozen' due to state budget cuts. One currently vacant FTE Public Health Nurse Coordinator position is in recruitment at the interview stage. The remaining 0.5 FTE of the coordinator position (filled half-time by Ms. Hoerbinger) also remains vacant, and in recruitment.

E. STATE AGENCY COORDINATION

New Hampshire's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. By establishing common goals and objectives in a multitude of collaborative relationships, Title V has greatly expanded its "reach" in both the state family and the community.

Title V staff participate in numerous state-level committees and legislative workgroups, such as: the Governor's Commission on Domestic and Sexual Violence, the Governor's Domestic Violence Fatality Review Committee, the Child Fatality Review Committee, and the Perinatal Alcohol, Tobacco, and Other Drug Use Legislative Task Force. An extensive table of Title V membership on and involvement with various task forces, commissions, committees, and work groups is available by request from MCH.

In the interest of conveying the essence of how Title V coordinates and collaborates with other

organizations in New Hampshire, the following activities are highlighted:

RELATIONSHIPS AMONG STATE HUMAN SERVICES AGENCIES

Coordination of program activities takes place through joint efforts by Title V and other DHHS agencies on topics of mutual interest and concern. Community and national health issues and available data drive the investigation, analysis and development of strategies to respond to these concerns.

Infertility Prevention Project:
The Family Planning Program (FPP) coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual chlamydia screening and treatment for female FPP clients between ages 15-26. Federal monies for this screening project are for women in the targeted category who would not otherwise be able to afford this screening. Funds are provided to the PHL for testing and to STD/ HIV for treatment.

TANF & Family Planning:
This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. Programming focuses on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy. Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs. Program expansion in 2002 occurred with the Teen Pregnancy Prevention Curriculum Project. TANF provided funds to promote implementation of teen pregnancy prevention curricula, with the FPP administering the effort and reimbursing local agencies, such as schools and Teen Clinics, to implement evidence-based curricula. To document effectiveness, a comprehensive evaluation of the project's implementation over the past three years is nearing completion.

Medicaid, TANF & Home Visiting New Hampshire (HVNH):
This project supports 18 home visiting programs statewide with TANF and Title V funds. HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. Expansion from 3 pilot programs was achieved through collaboration with Medicaid and TANF, with MCH as the lead agency and backing from the then-active Governor's Kids Cabinet.

Medicaid & MCH:
MCH has worked with Medicaid to develop and implement local Medicaid codes that pay for MCH-related services, such as child and family support and expanded prenatal services. MCH and Medicaid staff provide training to agencies in the use of the codes; Medicaid QA auditors inform MCH of identified needs for additional training. In 2005, MCH staff participated in Medicaid's initiative to develop a new IT solution for Medicaid billing.

SCHIP & Title V:
MCH collaborates with NH SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup (QCHIP) and the workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects.

SMS care coordinators inform uninsured families about the NH Healthy Kids (Medicaid) programs and send applications. A designated care coordinator (Kaiser) provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to NH Family Voices as well as to SMS.

State Department of Education (DOE):

Coordination with the DOE occurs through several MCH programs. The Adolescent Health Program (AHP) collaborates with the DOE manager of the YRBS to select questions for inclusion and to assure a representative sample. MCH staff participate in a DHHS/DOE initiative to develop a Coordinated School Health Plan and other activities to improve the health of school age children. The School Nurse Consultant maintains a listserv for school nurses and MCH staff post items and conduct surveys through this venue. MCH also works with the DOE on motor vehicle restraint activities. The FPP collaborates with the HIV Prevention Coordinator on teen pregnancy and STD prevention training and education programs for teachers.

Division of Behavioral Health (DBH):
Collaboration with the DBH, DOE, and the Division of Developmental Services (DDS) is illustrated by the Children's Care Management Collaborative (CCMC). This group models state level collaboration to ensure that our collective resources provide access to a full array of community-based services and supports for families with children and adolescents who have or are at risk of serious emotional disturbance, developmental or educational disabilities, substance abuse issues, or special health care needs. A product of the CCMC is the development of 14 Regional Infant Mental Health teams across the state. These teams are supported with braided funding from the DOE, DBH and Title V. MCH and SMS staff are active members of the CCMC.

Division of Children, Youth and Families (DCYF):
MCH collaborates with DCYF on several projects and committees. A representative from DCYF is a member of the NH Child Health Month Coalition discussed later in this section. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the NH Child Fatality Review Committee, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board members of the NH Children's Trust Fund. The DCYF Division Director is also a member of the statewide suicide prevention plan implementation team facilitated by the Adolescent Health and Injury Prevention Programs.

DPHS Bureau of Prevention Services (BPS):
MCH collaborates with the BPS to produce a brochure on Fetal Alcohol Syndrome. The BPS and MCH distribute brochures to their respective contract agencies and other stakeholders. MCH collaborates with the BPS on a statewide poison prevention committee and a BPS representative is a member of the NH Child Health Month Coalition discussed later in this section.

DPHS' Health Statistics Section (HSS):
A CDC core injury surveillance grant was awarded to the HSS in 2002, enabling the hiring of an injury surveillance manager and expansion of injury surveillance activities. This collaborative effort with MCH produced a state Injury Data Report and a draft statewide injury prevention plan, along with continued work by the Injury Advisory Committee and many data-driven programmatic efforts.

DHHS Health Data Users' Workgroup:
The Health Data Users' Workgroup was formed in 2005 to maximize the quality and efficiency of data related activities that support the functions of DHHS and promote the health of New Hampshire citizens. The group provides members with cross-training, collaborative problem solving, guidance, and access to appropriate resources related to: dataset information; analysis methods and interpretation; confidentiality and privacy; dataset and survey development and infrastructure; and future dataset contents and quality. MCH staff participate in this group.

Women's Health Week Coalition:
This collaborative group, chaired by the FPP Manager, was begun in 2002 as an initiative to promote women's health week activities and has evolved into an ongoing concern. Representatives from MCH, WIC, Health Promotion and Tobacco Prevention and Control meet regularly to address women's health activities. The group provides an epicenter from which to coordinate a more comprehensive approach to Women's Health within DHHS.

HIV Community Planning Group:

The FPP Manager sits on this group that develops priorities for HIV prevention work. In part because of this collaboration, the FPP was awarded a competitive grant to increase the integration of HIV prevention counseling and testing at family planning sites in the most highly impacted state communities.

MEDICAID and CSHCN

NH Medicaid launched an intensive initiative in 2003 to increase access to dental care for Medicaid and other underserved families. Medicaid reimbursement rates were raised for the codes that represent most of the dental therapies dentists use to provide comprehensive oral health care. Other strategies included forming a strong partnership with the New Hampshire Dental Society, reducing the administrative burden of claims processing, designing ongoing parent and PCP education programs, and improving coordination of oral health programs across the DHHS. While the increase in access in general has been brisk, there remain some populations, such as CSHCN, that find few providers able and willing to provide oral health care. The objectives of the Medicaid initiative include improving access to dental care for those populations through provider outreach and education efforts.

RELATIONSHIPS WITH OTHER HEALTH AGENCIES

Local Public Health Agencies:
MCH works with the 2 existing local health departments, in Manchester and Nashua, on issues of mutual concern. For example, the MCH provided funding to both health departments to conduct focus groups with minority populations through the SSDI grant in 2001. On an ongoing basis, the CLPPP funds both health departments to do follow up and nursing case management for children in those areas with elevated blood leads.

Public Health Networks (PHN):
MCH and the PHNs are beginning to collaborate more as the PHNs progress from fledgling public health programs to active forces within their local communities. The MCH Director participated in grant review for PHN applications in the last competitive bidding cycle, and presented on MCH programs at a 2004 PHN coordinators' meeting. One PHN was selected as the pilot site for the Frameworks implementation discussed below. MCH programs continue to seek out ways to educate PHNs on MCH issues and promote collaboration with other public health programs at the community level.

Federally Qualified Health Centers (FQHCs):
Seven FQHCs in New Hampshire provide direct care and enabling services to MCH populations, in part through Title V funds. MCH coordinates closely with the Rural Health and Primary Care Section to assess service needs, ensure appropriate scopes of services, and provide quality assurance monitoring for the FQHCs. MCH staff review proposals for these contracts, reviews agency workplans and performance measures, and administer QA activities through site visits and development of review tools. MCH contract agency directors attend quarterly meetings chaired and conducted by MCH. Sections IIIA, B, and D, and Sections IVB, C, and D contain additional information about the relationship with these safety net providers.

Primary Care Association:
The Bi-State Primary Care Association serves community health centers in New Hampshire and Vermont, providing advocacy and support for these agencies. MCH representatives attend Bi-State presentations when appropriate and some members of the Bi-State PCA Board of Directors are directors of MCH contract agencies that attend MCH quarterly Directors' meetings.

Tertiary Care Facilities:
MCH and SMS collaborate with the state's two tertiary care facilities, Dartmouth Hitchcock Medical Center (DHMC) and the Elliot Hospital, as needed. For example, MCH staff regularly present at the DHMC Perinatal Program's nurse manager meetings to update the community nurses on MCH issues and activities. Several DHMC physicians are members of the Newborn Screening Advisory

Committee. SMS supports Child Development and Neuromotor Programs at DHMC.

RELATIONSHIPS WITH TECHNICAL RESOURCES

Educational Programs & Universities:
Title V frequently coordinates with educational programs and universities. For example, the IPP funds the Injury Prevention Center at Dartmouth Medical School to provide statewide population-based injury services and works with them on many injury initiatives. MCH and SMS collaborate with Dartmouth's Birth Conditions Program, NH's birth defect surveillance system, to assure access to hospital records for case finding and provide care coordination for children with these conditions.

MCH contracts with the University of New Hampshire (UNH) Institute of Health Policy and Practice to fund an MCH epidemiologist, as discussed in Section IVB. MCH AHP staff participated in the creation of the UNH Center on Adolescence, a clearinghouse of best practices and information for researchers and communities on adolescent concerns. The AHP Coordinator is working with the Center to implement the statewide Adolescent Health Strategic Plan.

The MCH Director is a member of the Boston University School of Public Health MCH Department's Advisory Committee. BU staff will work with MCH in 2005 to develop a plan addressing prenatal disparities in the state. In addition, the Adolescent Health Program Coordinator participates in activities provided by the Boston Children's Hospital Leadership Education in Adolescent Health program.

Efforts to increase collaboration with the Dartmouth Medical Center/UNH Leadership Education in Neurodevelopmental Disabilities (LEND) program receive particular emphasis. Collaborative clinical and educational activities have occurred as a result of joint planning. The Child Development Program at Child Health Services (Manchester), and the Seacoast Child Development Program at UNH, under SMS contracts, are working on strategies to share professional expertise and increase the cultural competence of LEND trainees. SMS staff (Collins) recently participated in a 2-day regional LEND conference on cultural competence. The conference activities are related to initiatives of Kaiser-Permanente Hospital. Conference materials are being disseminated to community-based agencies.

Northern New England Poison Control Center:
The New England Poison Control Center, affiliated with Maine Medical Center, is NH's contractor to provide poison control activities. Funded by the Bioterrorism grant, the Poison Educator, sits within MCH. In addition, the IPP collaborates with the Poison Educator on many programmatic activities. As discussed in Section IIIB, MCH provides logistic support to the educator and oversight to activities within NH, including monitoring of the regular report on center calls.

Child Health Month Coalition:
MCH continues to Chair the state's Child Health Month Coalition, a collaborative effort between MCH Child Health and IPP, SMS, the NH Pediatric Society, the Injury Prevention Center at Dartmouth, the Safe KIDS Coalition, Children's Hospital at Dartmouth (CHaD), and DCYF. The coalition sponsors a yearly mailing to over 5,000 health and social services professionals, schools, hospitals, and agencies that work with children and families, and a web page hosted by the CHaD. Improved use of listserves and email lists in recent years has increased the distribution of the materials.

New Hampshire Coalition against Domestic and Sexual Violence:
MCH is represented on various workgroups including the education subcommittee of this statewide coalition. MCH has hosted joint education sessions on domestic violence and pregnancy with community health center staff.

Dartmouth-Hitchcock Medical Center:
The MCH Prenatal Program collaborated with Dartmouth to create a Perinatal task force that is establishing updated clinical procedures and will host best practice seminars on topics such as helping patients quit alcohol, tobacco, and drug use during pregnancy; psychotropic medication use in

pregnancy; genetic screening; and prenatal nutrition and weight management.

Other State Agencies & the IPP:
The IPP works with the NH Highway Safety Agency, and Departments of Safety, Transportation, and Education on all restraint issues. The IPP also participates in the Frameworks project, an innovative adolescent suicide prevention program that has developed intra-disciplinary, community level protocols for use in the event of suicidal attempts and threats, and for postvention. The initial planning process was MCH funded, and the MCH Director sits on the Frameworks Advisory Board. See Section IVC for additional information.

TITLE V & EPSDT

The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. Diana Dorsey, MD, shares a staffing position between the SMS Section and Medicaid. Dr. Dorsey provides pediatric consultation on EPSDT issues, with a particular focus on issues of medical necessity.

TITLE V & OTHER FEDERAL GRANT PROGRAMS

WIC:
Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion and injury prevention strategies are shared across programs in both state office and in communities. Lacking an MCH nutritionist, consultation from WIC nutrition staff on key nutrition issues impacting women and children is critical. For example, MCH staff collaborated with WIC and the NH March of Dimes to develop a folic acid public education campaign in 2000. The WIC Breastfeeding Consultant assisted MCH to develop a handout educating families on the dangers of bedsharing for the fall '05 Child Health Month Coalition packet mailing. WIC shares educational material with MCH contract agencies either directly or through MCH sponsored mailings and meetings. WIC staff present on nutrition-focused topics at MCH meetings and the Child Health Nurse Consultant provides updates on MCH programs at WIC meetings.

Title X Family Planning Program (FPP):
The NH Title X program is a major unit within MCH and is administered by the MCH Director, ensuring a seamless coordination between MCH and reproductive health services. MCH staff meetings, the yearly retreat and other planning activities include both MCH and FPP staff. The FPP Manager participates in the MCH Management Team. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens.

Developmental Disabilities:
The SMS Chief (Bumbalo) represents Title V on the Interagency Coordinating Committee for Part C.

In addition, HVNH has partnered with the Division of Developmental Services by developing a series of trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. These trainings were so well received that they are now proposed to be an annual event. Trainings for Fall 2006 will focus on the specific needs of infants in the first 12 months.

Early Childhood Comprehensive Systems (ECCS):
This MCHB-funded initiative is bringing together partners from a wide variety of fields to develop a statewide plan for early childhood systems. MCH has taken the lead in coordinating grant activities with a contracted facilitator through Mills Consulting Group. From this project has grown an additional initiative of community-based public and private funders that provide early childhood and family support programming. The "Gathering of Funders" meets quarterly to better understand and streamline the application, reporting and data collection requirements across funders.

Childhood Lead Poisoning Prevention Program (CLPPP):
As noted in Section IIIC, the CLPPP again resides within MCH and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children. To achieve the goal of eliminating childhood lead poisoning, the CLPPP collaborates with a wide variety of partners, such as the NH Property Owners Association, many housing authorities, health care providers, Dartmouth Medical School and various community-based organizations.

PHHS Block Grant:
This CDC grant and state funds support most IPP activities, including the statewide Injury Prevention Center at Dartmouth and NH Coalition against Domestic and Sexual Violence contracts.

F. HEALTH SYSTEMS CAPACITY INDICATORS

IIIF. Health Systems Capacity Indicators

The following provides an overview of the Title V program's ability to monitor the health systems capacity indicators:

#01: The rate of children hospitalized for asthma (10,000 children > 5 years of age)

The Asthma Control Program report "Asthma in New Hampshire, 1990-2002" reports that in 2002, 17.7% (95% CI: 15.7-`9.7) of adults had a child (17 or younger) in their household diagnosed with asthma. The 2001 inpatient hospital discharge rate for children age 0-4 was 12.8 (N=98) per 10,000 population, and is the highest in NH, following the rate for adults age 65 and older (9.7). The Healthy New Hampshire 2010 target is 7.9 per 10,000 population age 0-17. The baseline for this group was 10.5 per 10,000 in 1998. The hospitalization rate was 8.8 per 10,000 population for this age group in 2001. It is anticipated that the Asthma Control Program will have a beneficial effect on the current pediatric hospitalization rate of 12.9 per 10,000 children > 5 years of age.

This information is currently available to the Title V program through the Hospital Uniform Discharge Data Set and Medicaid program data files.

#02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen

This information has been available through the Medicaid program data files in the past and, with the implementation of the new Medicaid Decision Support System, MCH is hopeful it will eventually have direct access to Medicaid data.

#03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen

This information has been available in the past from the Medicaid Program. In addition, as a participant on the state's QCHIP (NH SCHIP quality assurance workgroup), MCH has been granted access to a draft report of the "Evaluation of the Quality of Care in the Children's Health Insurance Program" from the Healthy Kids Program, which contains data on average number of primary care visits by continuously enrolled children under age one year on Healthy Kids Gold/Medicaid for both Fee for Service and Managed Care participants.

#04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 % on the Kotelchuck Index

This data is available through the Division of Public Health Services' Health Statistics and Data Management Section (HSDM) and is obtained on a yearly basis.

#05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH

populations in the State

This information is available through the HSDM and Medicaid program data files. Some of this information is available from the Healthy Kids Program's not yet released report "Evaluation of the Quality of Care in the Children's Health Insurance Program: New Hampshire Healthy Kids FY2003".

#06: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children and pregnant women

This information is available from Medicaid and New Hampshire Healthy Kids. See above re: the unreleased report. The MCH Child Health Nurse Consultant is a member of the SCHIP quality assurance workgroup ("QCHIP") and the workgroup overseeing the Robert Wood Johnson-funded "Covering Kids and Families" three pilot community projects.

#07: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year

This information is available through the EPSDT program.

#08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.

New Hampshire reports that 1,422 children under age 16 are receiving SSI, as of December 2004, per the National Healthy and Ready to Work Center. Of these, 186 (13%) are enrolled in the NH CSHCN program. The number of New Hampshire children under 18 receiving SSI cash benefits has steadily decreased from 1998 to 2003. The 8% decrease (from the 1998 total of 1860) has been attributed to the continuing economic prosperity in the state, rather than welfare reform. NH children under 18 receiving SSI for their own disability numbered 1710 in 2003, per the SSA Report for December 2003.

According to the National Survey of Children with Special Health Care Needs, 2001 data for NH, only 2.26% of the NH CSHCN surveyed were receiving SSI for their own disability, indicating an under-representation of this population in the survey. SMS surveyed the SSI child population in fall 2004, (reference NPM #4 and the Needs Assessment) which provided a more comprehensive ‘picture' of this group. The survey, titled "Insurance/Cost-of-Care Survey of Children with Special Health Care Needs, 2004" was sent to 1141 of these families. The instrument was carefully constructed to utilize selected questions from the National Survey of CSHCN, in the major areas of insurance, impact, and access.

Further assessment will be undertaken to better determine the care coordination needs of this population of NH CSHCN, and will be included in future policy discussions regarding the provision of services to this group.

#09A: The ability of States to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data

Through the SSDI grant, the MCH is developing collaborative relationships to enable access to data from DHHS and other agencies, as well as facilitate linkages between MCH program data and other data sets (e.g. Vital Records). The Section continues to work on linkage of birth certificate and Newborn Hearing Screening Program data to assure that all newborns are screened for hearing loss at birth. Planned expansions of data linkages include birth data with Prenatal and Newborn Screening Program data, as well as Medicaid and WIC data with MCH program data. These linkages will assist the Section in assessing the MCH population and evaluating MCH programs.

#09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

The New Hampshire Tobacco Prevention and Control Program administered the NH Youth Tobacco Survey in October and November of 2001. This survey provides representative data of public middle and high school students. The NH YTS was administered again in November 2004. The survey has been completed and is being analyzed. Data will be available by June 30, 2005.

The NH Youth Risk Behavior Survey (YRBS) also collects information on adolescent smoking but only with the 2003 administration of the NH YRBS was representative data provided for the first time since 1995. Collaboration between the DOE, which administers the survey, and DHHS, which has epidemiological resources to contribute, has successfully overcome previous barriers. MCH and the Bureau of Prevention Services are working together to fund local implementations of YRBS in 2005, to obtain program specific information at the local level. We anticipate YRBS data will be available in the Fall of 2005.

#09C: The ability of States to determine the percent of children who are obese or overweight.

There are currently few ongoing efforts to collect information on obesity and overweight for all children. The last year statewide childhood obesity data was collected and released was 1991. The NH YRBS collects self-report information on obesity and overweight for the high school population but has provided representative data only once since 1995. School nurses in NH collect this information but there has not been an attempt to combine and analyze this data over the past decade. A NH Healthy Schools project initiative, in which MCH participates, has applied for funding to work with school nurses and health educators to collect, analyze and publish this data for the K-12 population.

According to the NH Nutrition Education Coalition, 9% of NH high school students are obese (Body Mass Index [BMI] 95th percentile) and 15% are at risk for obesity (BMI 85th-94th percentile). A pediatrician needs assessment resulted in this organization developing a Pediatric Weight Management Toolkit that includes the Recommended Pediatric Weight Screening Guidelines (decision-making trees), articles, fact-sheets, resource guides and patient handouts. Over 2000 toolkits have been distributed to NH pediatric health practitioners; evaluation will provide more data in the future.

It is estimated that 25% of New Hampshire children and teens can be considered obese or at risk for obesity, a proportion which has more than doubled in the last few decades. A recent study commissioned by the NH Department of Education shows that our third-graders are significantly fatter than their peers across the country as 36.6 % of girls and 41.5 % of boys were considered overweight or at risk for overweight.

Funded through a federal Team Nutrition grant and analyzed by the University of New Hampshire's Department of Health Management and Policy, the New Hampshire Health Assessment Project gathered information from 1,538 8-year-old third-graders in elementary schools in all 10 New Hampshire counties by measuring their BMI, a ratio of height to weight. The New Hampshire results showed that 126 girls, or 17.4 %, are considered at risk for being overweight compared with 72 or 9.9 % nationwide, and 139 New Hampshire girls or 19.2 % are considered overweight compared with 36 girls or 4.9 % nationally. Among New Hampshire boys, 148, or 18.2%, are considered at risk to be overweight, compared to national figures of 81 or 9.9 percent, and 189 boys (23.3 %) are considered overweight, compared to 41 or 5 percent nationally. A similar study done in city schools in Manchester found that two out of five first-graders were overweight (i.e. 40 %).

Data from the WIC Program's 2003 Pediatric Nutrition Surveillance System shows that New Hampshire exceeds national rates for some of the weight-related indicators for the children enrolled in WIC. Prevalence of children on WIC under age five who were at risk for overweight (85 -- 95th percentile) was 19.4% compared to the national rate of 15.4%. The prevalence of children over age two and under age five who were overweight (over 95th percentile) was 15.6%, compared to the national rate of 14.3%. These trends have been increasing since 1994. Looking at the data on overweight children greater than 95th percentile by race and ethnicity in New Hampshire, the highest

prevalence group was between ages one and two years, and was highest for the Hispanic children; the lowest was for Asian/Pacific children.

Data continues to show that childhood obesity is a problem in New Hampshire. Based on research done in other states, it is likely that childhood obesity is related to a combination of factors, such as lower income and education levels and a growing number of single-mother households. It is important to note that studies have shown that overweight adolescents have a 70 % chance of becoming obese or overweight as adults.

It is clear that a statewide initiative is needed to address the problem of childhood obesity in New Hampshire. In response, the Healthy New Hampshire Foundation, a charitable organization created in 1997 with funding from the merger of two major health insurance companies in the state chose reducing childhood obesity as a grantmaking focus in 2004. A planning grant was given to the New Hampshire Healthy Schools Coalition to address the issue, focusing on how "best practice" interventions in the state's school system can make a difference, and 20 New Hampshire schools were funded to increase physical activity, teach nutrition education, support a healthy food environment, and work with families within their communities. The New Hampshire DHHS is currently surveying key state and local stakeholders to assess and identify the need and interest in developing a Comprehensive Statewide Obesity Prevention and Control Plan. A comprehensive list of statewide obesity prevention efforts and resources is also planned. In collaboration with these efforts, SMS and MCH plan to organize a summit in spring ‘06 bringing together the various obesity prevention projects state wide to share information and resources (see new State Performance #9).

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

New Hampshire's priorities are selected based on many factors, such as the political and socioeconomic climate of the state, needs assessment findings, and emerging health issues. Sections II and IIIA address the process for choosing priorities based on needs assessment findings and statewide capacity, determining the importance of competing factors that impact health services delivery, and prioritizing identified needs. This section describes current considerations in developing state priorities. The complete list of Title V priorities is located in Section IVB.

The 2005 Title V needs assessment, found in Section II, provides an overview of maternal and child health in NH, describes health status indicators, identifies disparities and gaps in health services, and led to the targeting of priority concerns. Findings point to potential areas of intervention, such as:

- Creating a comprehensive, multi-program plan to intervene with at-risk pregnant women in order to reduce LBW.

- Developing policies to promote Medicaid enrollment and care utilization.

- Assessing cultural competence in local and state MCH programs and creating supports to enhance services.

- Improving prenatal care access in southern counties to reduce birth disparities in minorities.

- Expanding YRBS use to improve the understanding of vulnerable adolescent populations.

- Improving understanding of the primary care workforce distribution and its' effect on access to care.

- Addressing the impact of pediatric mental health and dental provider shortages.

- Creating strategies to protect children at higher risk for lead poisoning, such as malnourished refugee populations, from NH's aging housing stock, while avoiding stigmatization.

- Examining funding distributions for MCH programs, addressing barriers to care, improving access, and whether efforts to improve enrollment in SCHIP and Medicaid impact health outcomes.

-Implementing best practices to reduce teen injury from motor vehicle crashes.

- Strengthening the state infrastructure to promote the integration of mental health services for children, youth and their families into primary care practices.

- Enhancing systems development to reduce fragmentation among multiple entities that provide resources to intervene on the prevalence of obesity among children.

- Confronting the shortage of trained respite and childcare providers to serve families of the most medically and behaviorally complex CSHCN.

At present, some economic factors affecting NH's population are fluctuating. Rising unemployment in some regions, a soaring housing market, and Medicaid modernization are some issues that may influence the health of New Hampshire's families over the next years. In addition, scarce state resources and federal funding reductions threaten the existence of some state programs in SFY06. The full effect of this economic climate is difficult to predict, but the potential continues for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

New Hampshire continues to struggle with data capacity issues; data capacity was a top priority identified in NH's CAST-V process. Some Title V program data is of very limited use. Lack of access

to birth files and other vital records data has presented a barrier to basic analysis and data linkage efforts in recent months. The MCH Data Team has assessed data and information needs for MCH programs and created an action plan to address these needs.

Program development for CSHCN, based on identified priorities, has become easier with the availability of data from the National Survey of CSHCN 2001. Additionally, stakeholder input from the needs assessment and the associated data have been crucial to the capacity evaluation process. Title V's ability to develop interdependent collaborative relationships with stakeholders who share concerns for CSHCN has improved in the past few years and the result is a heightened interest, statewide, in determining and strengthening the infrastructure for community-based, family-centered, care coordination, as an overarching priority. New State Performance Measures #8, 9, and 10 are one outcome of this heightened stakeholder interest.

Population-based needs for care coordination remains a consistent theme across all MCH pyramid levels for CSHCN. The needs assessment data evidences what we already know: that families need, value, and request assistance with care coordination for their children. Additionally, needs assessment results for CSHCN indicate that further evaluation is warranted for the specific issues of mental/behavioral health, respite and child care workforce development, and care coordination for CSHCN who receive Medicaid and SSI benefits.

In consideration of these factors, Title V recognizes the importance of identifying broadly focused priority needs. The needs of each MCH population have been evaluated, including CSHCN, and the critical areas of mental health, oral health, injury prevention, and childhood obesity are acknowledged. Concerns about maintaining current service levels and improving Title V capacity were integrated. A priority addressing the foundation of MCH practice will further Title V's focus on infrastructure and population-based services, while a priority addressing the preservation of effective public health programming will remind us of our core mission and the vulnerable populations we serve. Priorities are systems-focused and likely to respond to evidence-based interventions. Directing limited MCH resources to these areas is critical to maintain the health of New Hampshire's families.

B. STATE PRIORITIES

RELATIONSHIP OF STATE PRIORITY NEEDS & PERFORMANCE MEASURES

New Hampshire has revised priority needs, as described in Section II, as follows:
1. To improve the Title V program's ability to impact the health of MCH populations through data collection and analysis, identifying disparities, examining barriers to care, and researching and implementing best practice models (All NPM & SPM)
2. To assure safe and healthy pregnancies for all women, especially vulnerable populations (NPM #8, 15, 17, 18 & SPM #2)
3. To assure safe and healthy environments for MCH populations, including those with special health care needs (NPM #13, 14 & SPM #3)
4. To decrease dental disease in MCH populations (NPM #9 & SPM #4)
5. To decrease unintentional injuries among children and adolescents, including those with special health care needs (NPM #10 & SPM #5)
6. To promote healthy behaviors and access to health care services for adolescents, including those with special health care needs (NPM #2-6, 8, 13, 14, 16 & SPM #6)
7. To preserve effective public health programming, including an infrastructure of safety net providers, to address the needs of MCH populations (All NPM & SPM)
8. To improve access to mental health supports and services for children and youth, including those with special health care needs. (NPM #2, 3, and 5; SPM #8)
9. To decrease the prevalence of childhood overweight and obesity. (SPM #9)
10. To increase the trained workforce available to provide respite and child care for medically and behaviorally complex children with special health care needs. (NPM #2, 5; SPM #10)

ACTIVITIES RELATING TO PRIORITY NEEDS

MCH and SMS strive to provide a state Title V program addressing all state priority needs. Many priorities relate to performance measures; those discussions are included in Sections IVC and D. Some activities clearly relate to priority needs, but are not integral to the performance measurement system and are included here.

PRIORITY #1

SSDI GRANT: MCH will improve data capacity through linkages, such as linking EHDI data with birth certificate data to assure that all infants are screened. Data linkages were on hold this past year pending an MOU between DHHS and the Secretary of State regarding public health access to vital records data. MCH issued an RFP to create a web-based module for prenatal program data, to be implemented this year. The MOU is now completed and MCH's IT liaison is proceeding with data linkage activities.

MCH HEALTH POLICY CAPACITY: MCH has formed a Data Team, consisting of the MCH epidemiologist, SSDI Coordinator, QA Nurse, Program Evaluation Specialist and MCH Director, to improve MCH evaluative capacity. This past year, work focused on the needs assessment and improving data collection from local programs. In the coming year priorities will be implementing the Data Action Plan from CAST-5 and creating a systematic approach to data through business planning.

HOME VISITING NEW HAMPSHIRE (HVNH) BEST PRACTICES: The HVNH Best Practices project sought to identify best practices in home visiting by quantifying the costs of providing services, incorporating staff and client satisfaction and clinical outcomes. The project, completed in 2005, provided information on six HVNH agencies, showing that participants and staff are very satisfied with HVNH services. Clinical outcomes and costs varied widely. Adjusted cost for a care episode ranged from $3,170 to $10,710; cost reduction opportunities varied from 4 to 35%. Significant cost drivers included the % of non-direct clinical time; time spent on visits and associated functions; and the staff mix of home visitors and nurses. HealthMETRICS, the project contractor, developed 22 detailed recommendations for participating agencies; some recommendations are transferable to other HVNH programs. The project's Executive Summary is included as an attachment to this Section.

SIDS NATIONAL DATA BASE: The NH SIDS Program will be participating in the data collection of the national "SIDS in Child Care Setting" study through the Children's National Medical Center in 2005.

PRIORITY #2

BIRTH OUTCOMES WORKGROUP: MCH will address disparities between Medicaid and non-Medicaid populations in IMR, LBW, and prenatal care and explore other areas where intervention may improve prenatal outcomes. A plan will be developed to address these issues based on best practices. Meetings have been held with Medicaid, WIC and NH Tobacco Prevention and Control to discuss a collaborative effort to address poor prenatal outcomes. MCH requested TA from Boston University's Dr. Milton Kotelchuck in planning this initiative.

PRIORITY #3

HVNH: HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. Begun as an MCHB CISS grant in 1996, the program is now in 18 areas of the state. HVNH teams, including a nurse and parent educator, use the nationally recognized Parents as Teachers curriculum and a resource developed in New Hampshire, HVNH Prenatal and Infant Cue Sheets, to guide visit content. The focus areas are prenatal smoking cessation, family planning, and maternal depression. The project is funded through

TANF and Title V funds, and Medicaid reimbursable home visits as discussed in Section IIIE. Plans for 2005 include a planning grant for an urban area of the state previously unable to support an HVNH program.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): MCH administers HCCNH, entwining its goals of health and safety in child care settings with those of the ECCS initiative. MCH works with the state's Child Development Bureau (CDB) to provide trainings to child care providers with curriculum developed by this project. With blended funding from SMS, CLPPP, and the NH Immunization program, MCH plans a CCHC pilot for 2005 to support the role in local communities by funding CCHCs housed in regional Child Care Resource and Referral centers. This will ensure that such topics as caring for CSHCN, lead poisoning prevention, and accurate immunization documentation will be of highest priority.

EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (ECCS): This MCHB-funded planning process will continue through the upcoming year with implementation of a comprehensive plan beginning in July 2006. HCCNH objectives are complexly integrated within this project. SMS (Bumbalo) collaborates with MCH colleagues on grant activities related to integrating Medical Home and Infant Mental Health programs.

SAFE SLEEPING EDUCATIONAL EFFORTS: The MCH Child Health Nurse Consultant/SIDS Program Coordinator includes SIDS risk reduction and safe sleeping information in all presentations, as a result of the increasing infant deaths in NH involving bed sharing. In follow up to a 2004 Child Fatality Review Committee recommendation, a handout on educating parents about the dangers of bed sharing has been developed for the Fall 2005 Child Health Month Coalition packet mailing.

REFUGEE LEAD STUDY: In 2004, a cluster of refugee children with elevated blood lead levels was identified in Manchester, NH. A descriptive case series investigation of this cluster concluded that lead poisoning occurred after resettlement in NH and that follow up lead screens for refugees is useful, especially where malnutrition is a complicating factor. A cohort study is now underway to examine potential risk factors among refugee and non-refugee children living in comparable housing in Manchester. A questionnaire has been administered to the refugee families in the cohort in addition to estimated risk appraisals of the housing. The final results will be made available locally and nationally and a manuscript will be written and submitted to a peer-reviewed journal.

PRIORITY #4

ORAL HEALTH & HOME VISITING: In light of evidence that pregnant women with dental disease are at higher risk for premature and low birth weight infants, an oral health module for HVNH was developed. Oral Health funds supported HVNH activities to promote collaboration between the dental community and HVNH programs in the 18 sites. HVNH programs were successful in developing educational strategies and leveraging resources to provide pregnant women and infants access to care. An oral health curriculum for grades K - 3 was implemented in all schools.

MANCHESTER ORAL HEALTH INITIATIVE: This year, MCH will provide additional financial support to the state's largest school dental program in an urban center experiencing a dramatic increase among immigrant and refugee students at risk for dental disease.

PRIORITY #5

INJURY PREVENTION PROGRAM (IPP): The IPP addresses injury more broadly than the performance measurement system. For example, the IPP leads a 50 member advisory group to address injury prevention needs statewide. The program manager is active in the national State and Territorial Injury Prevention Directors Association (STIPDA), the national advisory committee of the Children's Safety Network, and participates on a STIPDA assessment team. Intentional injury is addressed by funding 13 local domestic violence agencies for prevention, largely in school settings; developing a state plan to address violence against women; and participating in the NH Firearms

Safety Coalition. Unintentional injury priorities include chairing the NH Falls Risk Reduction Task Force and participating in the NH SafeKids Coalition advisory committee.

PRIORITY #6

ADOLESCENT HEALTH STRATEGIC PLAN: MCH released its statewide Adolescent Health Strategic Plan in 2004 and will disseminate findings and continue working with community partners this year. One focus area will be teen access to preventive health care. MCH will develop a youth development focused performance measure for its contract agencies and implement the new measure in 2006.

COMMUNITY YOUTH MAPPING (CYM) PROJECT: MCH funded a first training on CYM for those interested in community-level youth development. The CYM collects data on assets useful to youth; the main focus is to build a positive information infrastructure. CYM creates a complete picture and map on available services and support for youth and families and allows easy access to the information. MCH will continue to work with UNH Cooperative Extension to support implementation of this project in local communities.

PRIORITY #7

PERFORMANCE MANAGEMENT (PM) INITIATIVE: As discussed in IIIA, MCH continues to move toward a comprehensive PM system. Contract agency performance measures were refined this year and new site visit tools implemented, including self-assessment tools for contract agencies. MCH staff continue to provide training on performance measurement as part of a DPHS-wide initiative. The MCH Administrator, along with the DPHS Bureau of Policy and Performance Management Chief, will chair the DPHS Performance Improvement Committee this year.

FUNDERS' COLLABORATIVE: The ECCS Coordinator worked with the United Way of the Greater Seacoast (UWGS) to explore common goals in building community-based agencies' capacity to better understand, document, and disseminate outcomes of the community programs they fund. Both public and private funders have received similar messages from community-based partner agencies; multiple funding sources are asking agencies to develop data collection and evaluation plans, but these requests are not aligned. Surveys of both funded agencies and public and private funders were conducted. Results were then brought to grant makers through a meeting in March 2005. Eighteen individuals, representing the NH DHHS, NH DOE, numerous charitable foundations, United Ways, the NH Children's Trust Fund and the NH Women's Fund, attended. Discussions centered on how funders could align funding streams to maximize community impact and how systems could be improved to ease the burden on funded agencies. Although many stakeholders are involved in other ECCS efforts, this meeting was a unique opportunity to focus on the grant making process. Funders will continue to convene quarterly to address: networking and communication; developing a common language in applications and shared processes for evaluation; and coordinating strategies, including funding strategies, to increase community impact.

TITLE V RESOURCE ALLOCATION: SSDI staff will examine MCH needs and resource allocation. This may focus on geographic reallocation of funds, population-based services or particular populations, such as minority women. Focus groups will be conducted with women and families to learn more about barriers they face in accessing health care.

PRIORITY #8:

This is a new priority and new State Performance Measure. The rationale and plan for the coming year are discussed in Section II.

PRIORITY #9:

This is a new priority and new State Performance Measure. The rationale and plan for the coming

year are discussed in Section II.

PRIORITY #10:

This is a new priority and new State Performance Measure. The rationale and plan for the coming year are discussed in Section II.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			85	85	85
Annual Indicator			100.0	100.0	100.0
Numerator			7	13	11
Denominator			7	13	11
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

Appropriate follow-up at this point in NH is short term. The primary care physician is contacted to find out what action has been taken.

Notes - 2003

Appropriate follow-up at this point in NH is short term. The primary care physician is contacted to find out what action has been taken.

Notes - 2004

Appropriate follow-up at this point in NH is short-term. The primary care physician is contacted to find out what action has been taken.

Objectives are set lower than the 2004 result because of small numbers, i.e. missing on follow-up in the future would result in a signficantly lower result/indicator.

a. Last Year's Accomplishments

The first priority is always the daily task of managing the screening process statewide. This includes components such as working with individual birth hospitals to assure that the screening is occurring, the necessary tracking and follow-up of any abnormal screenings and the daily reporting out of screening results back to the birth hospitals. (PB, IB)

New Hampshire continues to contract with the New England Newborn Screening Program (NENSP) at the University of Massachusetts to perform screening for Dried Blood Spot specimens. The contract includes: transport of specimens, screening for state mandated disorders, screening for hemoglobinopathies upon request, TA regarding test results and follow up as needed, and storage of specimens.
The federal site visit report from the National Newborn Screening and Genetics Resource Center (NNSGRC), received in November 2003, was reviewed and a plan made to address the recommendations contained in this report. The first priority identified was the development of an Internal Operations Manual and work on this tool has begun. Other items included the development of a Refusal Form (completed) and a decision to utilize the website, www.savebabies.org, for any general requests received regarding "Expanded Screening Information". (IB)
The process to revise the program's Administrative Rules was begun. (IB)
Implementation of the recommendations of the Newborn Screening Advisory Committee to add four conditions to our current panel was initiated. (IB)
The program coordinator developed a Site Visit Tool and plans to make site visits to the birth hospitals. In preparation for these visits, copies of the NCCLS video series, "Newborn Screening: Blood Collection on Filter Paper" were purchased for each birth hospital. (IB)
The program coordinator continued to cultivate partnerships within our region through participation in New England Regional Genetics Group (NERGG) Board activities and the New England Consortium. (IB)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to manage the daily process of reporting out the follow-up.			X	
2. Continue to direct and support the ongoing work of the Newborn Screening Advisory Committee.				X
3. Continue to support the process to implement the recommendations of the Advisory Committee to expand our current panel to 11 conditions and assess addition of other conditions.				X
4. Disseminate the QA Tool to provide feedback to the birth hospitals on the process of newborn screening.				X
5. Develop an Internal Operations Manual to guide day-to-day program operations.				X
6. Continue site visits to birth hospitals for purpose of education and evaluation of newborn screening process.				X
7. Continue to support Data Linkage Project.				X
8. Continue to develop and nurture state and regional partnerships relative to Newborn Screening.				X
9. Support effort to obtain a medical consultant for the Newborn Screening Program.				X
10.				

b. Current Activities

First priority continues to be the daily management of the overall newborn screening process. (IB, PB)
Copies of the NCCLS video series, "Newborn Screening: Blood Collection on Filter Paper" were disseminated to all the birth hospitals in September 2004. Efforts to support the work of

the Newborn Screening Advisory Committee and the Data Linkage Project remain ongoing. (PB, IB)
The contract with the NENSP was renewed through SFY 07 for the 6 basic disorders in New Hampshire's screening panel. Efforts are underway to complete a competitive bidding process for the addition of 4 disorders recommended by the NH NSP Advisory Committee in 2003.
Efforts continued to support the work of the Newborn Screening Advisory Committee (IB).
Support of the Data Linkage Project continued, although this project encountered a number of barriers that stalled this work. (IB)
Efforts to develop an Internal Operations Manual for the program have been initiated. A plan to orient a number of other individuals to provide program coverage in the absence of the coordinator has begun and it is expected that the Internal Operations Manual will support this activity as well. (IB)
Efforts around quality assurance are underway. The QA tool to provide feedback to birth hospitals on several areas of specimen collection is ready to disseminate. Site visits to all the birth hospitals for the purpose of meeting those involved in the process and reviewing the process that occurs in each birth hospital have also been initiated (3 site visits made thus far). (IB)
Continued efforts to collaborate within the region are ongoing. (IB)
The need for a medical consultant to the program has been identified and the process to recruit for this via RFP has been initiated. (IB)
Proposed legislation (NH House Bill 108) that would ultimately allow filter paper fees paid by hospitals to be increased so that funding could be designated for additional conditions to be screened met some obstacles but appears to be moving forward. (IB)
At the May 2005 meeting of the Advisory Committee, there was a unanimous vote to recommend that Cystic Fibrosis be added to the screening panel. Efforts are underway to issue a competitive bid for laboratory services to analyze the five newly recommended conditions. (IB)

c. Plan for the Coming Year

First priority continues to be the daily management of the overall newborn screening process. This effort includes a number of components listed above and can be time consuming, leaving little time for special projects. (IB, PB)
The NENSP will continue to screen for 6 disorders in accordance with contractual requirements. NENSP was chosen in a competitive bidding process to screen for 5 additional disorders recommended by the NHNSP Advisory Committee. (IB)
The QA Tool to provide feedback to the birth hospitals on different components of the screening process is ready to be disseminated. It is expected that this will be a process that continues to evolve and change over time. (IB)
The work of the Newborn Screening Advisory Committee is ongoing. This year, the Committee will review the ACMG recommendations for a standard panel for newborn screening. (IB)
Completion of the process to revise the Administrative Rules of the program remains a priority as well as the Data Linkage Project, which has recently been stalled. Administrative rules are drafted and undergoing review through the Joint Legislative Committee on Administrative Rules. It is anticipated that they will become effective in October 2005. (IB)
With the passage of SB108, effective September 21, 2005, a restricted fund for newborn screening fees is authorized. This fund will assist the program in streamlining the process of adding disorders to the screening panel as well as directly ties revenues from screening fees to the costs of the laboratory contract. (IB)
Plans to make site visits to all of the birth hospitals are ongoing as time allows. (IB)
Development of the Internal Operations Manual as well as a plan to orient other personnel for program back up have been identified as high on the priority list and this effort is ongoing. (IB)
Proposal review and processing the contracts for the selected Medical Consultant and laboratory screening services for the additional five conditions will continue into FY06. (IB)
Participation in regional activities and collaboration with the other New England screening

programs will continue. (IB)

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				54.9	54.9
Annual Indicator			54.9	54.9	54.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.9	55.9	55.9	56.9	56.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Recent parent satisfaction surveys for clinical programs administered by the Special Medical Services Bureau reflect a high degree of satisfaction with services received. The response rate for the survey was 56% (N=195). Overall satisfaction based on 17 quality indicators was 95%. (Very satisfied, 79.4%; Satisfied, 15.5%). The highest score was for "Treated with courtesy-compassion (97.9%) and the lowest score was for "Told about parent groups" (55.2%).

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

SMS continued to support the NH Family Voices program and staff with a contract ($115,374) for FY 04-05

Professional staff continued to participate with NHFV and other parent and community volunteers on joint advisory committees that focus on improving services for children and families. The advisory group on insurance/funding issues developed materials that address a) alternative approaches to care, b) communication with providers, c) insurance law, d) paying for medications, e) private funding resources, f) access to specialists, g) public programs, h) organizing records, i) quality of care issues, j) choosing vendors and paying for durable medical

equipment. The advisory group on transition began development of educational materials for families and youth anticipating health care transitioning.

SMS staff worked on two quality assurance projects to improve parent satisfaction with services. Both initiatives focused on direct care activities associated with the Neuromotor Clinical Program. The first project involved reducing the amount of time between the clinic visit and the completion of final interdisciplinary reports for distribution to families and community providers. The goal is to have reports completed and distributed to families and providers no longer than six weeks after the clinic visit. Changes have been made in the transcription service and a chart audit to measure progress was completed in fall, 2004.

The second quality assurance initiative focused on improving continuity of care for children undergoing major orthopedic surgery. In the past both families and professionals voiced concerns regarding lack of communication between the clinic team and hospital personnel. To address this, SMS staff developed a perioperative protocol to be completed for each child prior to surgery. This information is now being sent to the hospital staff one week prior to the scheduled surgery. This procedure allows for planning (e.g., for post-operative nutritional concerns) and exchange of necessary information.

Clinic and hospital staff held joint meetings to discuss child and family needs and to determine necessary approaches and procedures. New Hampshire Family Voices staff were included in this process. Subsequent to this endeavor, nursing staff from the Concord Hospital submitted a description of this collaborative effort to the National Society of Pediatric Nurses and received an award for quality care.

Parent satisfaction surveys for clinical programs administered by SMS reflect a high degree of satisfaction with services received. The response rate for the survey was 56% (N=195). Overall satisfaction based on 17 quality indicators was 95% (Very satisfied, 79%; Satisfied, 15%). The highest score was for "Treated with courtesy/compassion" (98%) and the lowest score was for "Told about parent groups" (55%).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SMS continues to contract with and support the NH Family Voices program and staff.		X		X
2. SMS is contracting with the Upper Valley Support Group (Lebanon, NH) to provide family support services.		X		X
3. Special Medical Services continues to support the work of the SMS/NH Family Voices joint advisory group working on cost-of-care/insurance issues.				X
4. Increasing professional-parent collaboration is a major strategy intended to increase satisfaction with services.				X
5. The joint SMS/NHFV Health Care Financing Advisory Group planned and sponsored a statewide continuing education program for community-based providers.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

In addition to continuing support for NH Family Voices, SMS is contracting with the Upper Valley Support Group (Lebanon, NH) to provide family support services. This agency, through its Parent to Parent of New Hampshire network, provides one-on-one peer matches, emotional support (a listening ear), information and referral, and distributes written materials to families who have children with special health care needs. They provide consultation and technical assistance to coordinators who have been hired by other systems for parent matching and to representatives of other states who are using Parent to Parent of New Hampshire as a model for creating their statewide parent-to-parent networks. The Parent to Parent website is available for requesting matches, communicating with others via a message board and using a Just 4 Kids site.

Special Medical Services continues to support the work of the SMS/NH Family Voices joint advisory group working on cost-of-care/insurance issues. (See NPM 4) The advisory group endeavor relies on professional-parent collaboration, which is a major strategy intended to increase satisfaction with services. The joint SMS/NHFV Health Care Financing Advisory Group planned and sponsored a statewide continuing education program for community-based providers. Over 80 individuals attended a daylong program titled "How to Know What to Ask to Get What You Need."

c. Plan for the Coming Year

SMS will continue to support NH Family Voices with a contract for $193,247, and Upper Valley Parent to Parent Support with a contract for $16,800.

All SMS supported programs (contract and state supported) will be required to conduct and submit parent satisfaction surveys focusing on quality of care indicators. Based on the results of these surveys, each program will be asked to submit a plan for increasing satisfaction with services received.

According to the NH data from the National Survey of CSHCN, accessed from the Data Resource Center for CSHCN, 55% of families surveyed felt like a partner in decision-making and were satisfied with the services received (Outcome #1). Of those with insurance coverage, 45% did not meet the criteria for success for this outcome. Of those without coverage, 55% did not meet the criteria. Of the respondents reporting specific types of special health needs, 58% of those whose children had functional limitations did not meet the criteria. Thirty-eight percent of those managed by prescribed medications, 48% of those needing above routine services, and 42% of those reporting use of Rx meds combined with heightened service use, did not meet the success criteria for this outcome. These figures indicate that clinical services for NH CSHCN not under direct influence of the Title V program may need technical assistance and/or consultation to improve parent satisfaction.

An important strategy to increase diffusion of the principles of family-centered care will be to support the parent partners that are part of the medical home network and the MCHB-funded grant (Beyond the Medical Home). Mentoring and collaboration of efforts between the SMS contractor (NH Family Voices) and medical home sites will be encouraged. The goal is to provide training and support to family members to serve in advisory roles in order to increase participation in decision-making and satisfaction with care. A second strategy will be to explore the issue of family participation to improve the quality of care with major provider networks. Materials from the New England SERVE Shared Responsibility project will be available to provide support for possible joint initiatives.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55.9	55.9
Annual Indicator			55.5	55.5	55.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.9	56.9	56.9	57.9	57.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

SMS continued to collaborate with the federally funded MCHB projects in our region to determine the skills and competencies necessary to provide community-based care coordination. The State Title V CSHCN program continued to share information on models to determine the level and complexity of care coordination which are being tested by State-based coordinators. SMS continued to explore the potential for Medicaid support for care coordination in medical home sites, although this is difficult in the current financial climate. SMS again requested technical assistance for strategic planning regarding the issue of adequate insurance/cost reimbursement for care coordination services.

SMS staff continued to offer systematic ongoing consultation regarding individual children and families to medical home sites. In collaboration with CMHI and the Vermont Title V program, SMS provided financial support ($1000.00) for a bi-state conference, which celebrated the accomplishments of eight sites in achieving "medical homeness" and improving services offered to CSHCN. This two-day conference was held in Lebanon in February 2004. Major presentations were related to transition points and future sustainability of the medical home network. The Administrator (Bumbalo) and two staff members (Cahill, McCann) participated, to continue networking and planning for future collaboration with medical home sites.

In April 2004 SMS collaborated with the New Hampshire Leadership Education in Neurodevelopmental Disabilities Program (LEND) to offer a half-day seminar to medical home and other community coordinators on the topic "Differential Diagnosis and Mental/Behavioral Health Issues in Children". The workshop presentations focused on mental and behavioral health issues from different perspectives, including insights from practitioners and families. This collaboration between state Title V programs is supportive of the MCHB mission to develop infrastructure and the capacity of medical home sites to provide quality care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with Center for Medical Home Improvement (CMHI) staff to technical assistance to the Medical Home sites supported by the “Beyond the Medical Home” grant.				X
2. The nurse coordinator is a resource for the care coordination model, for medical home practice-based care coordinators (RNs and MSWs) in NH, and maintains a professional presence in SMS-based RN care coordination activities by carrying a caseload.	X	X		X
3. Provide training for medical home sites personnel, care coordinators, and other stakeholders regarding cost-of-care issues and strategies to secure needed resources for CSHCN and their families.				X
4. Convening and facilitating Medical Home Team meetings and other care coordination-related meetings that address the need to develop care coordination in medical homes, and to develop medical home practices.				X
5. Financial support is provided to current medical home sites for supplies and for certain training events.				X
6. Creating New Hampshire-specific medical home brochures (professional and parent versions) for statewide dissemination to increase education about the concept of medical home for CSHCNs.				X
7. Participation in strategic planning regarding NPM #3, utilizing the results of the NH Needs Assessment for CSHCN.				X
8.				
9.				
10.				

b. Current Activities

Community based-care coordinators meet monthly for continuing education and meet occasionally with community partners for case reviews and collaboration. One part-time nurse care coordinator (Hoerbinger) facilitates meetings for two medical home teams in Concord and one team in Dover.

SMS continues collaborative efforts with the Center for Medical Home Improvement which is now located at Crotched Mountain in Greenfield, N.H. The CMHI was awarded funding from MCHB for a four-year project titled "Beyond the Medical Home." The focus of this initiative is on integrating medical home sites with other community supports for CSHCN. SMS recruited for a state-based public health nurse coordinator position to support the activities associated with CMHI projects. The goal is to maintain the network of current medical home sites and to continue the focus on community-based systems of care.

Care coordinators, parent-partners, and other personnel from medical home sites were invited to attend the statewide conference on health care financing, "How to Know What to Ask to Get What You Need" which was held in October 2004 (see NPM #4). This program assisted medical home sites to increase their expertise in making requests to insurance companies to cover the cost of care and durable medical goods for CSHCN.

The 1st NH Medical Home Partnership Advisory Meeting was held in the fall of 2004. The intent is for this group of experts in the field (professionals and parents) to meet on a quarterly basis to develop and implement a strategic plan to sustain the medical home movement in New Hampshire. Such a structure would have the potential to address issues of sustainability and ongoing development. Although follow-up has yielded minimal response, there is consensus that the need is present. Statewide education planning was addressed in May 2005 with participants of the Center for Medical Home Improvement.

SMS supports the Medical Home practices by providing a $250.00 stipend to each Medical Home site (5 practices) for the purchase of educational material (texts, software, and references) for professional or patient education regarding the care of CSHCN.

c. Plan for the Coming Year

According to the NH data from the National Survey of CSHCN, accessed from the Data Resource Center for CSHCN, 55% of families surveyed reported receiving coordinated, ongoing, comprehensive care within a medical home (Outcome #2). Of those with insurance coverage, 44% did not meet the criteria for success for this outcome. Of those without coverage, 54% did not meet the criteria. Of those reporting specific types of special health needs, 57% with children with functional limitations did not meet the criteria.

SMS will continue to develop the staff position (nurse coordinator) affiliated with the Medical Home Initiative. This interaction is becoming more defined and continues to evolve. The Coordinator (Hoerbinger) is the SMS liaison to the Center for Medical Home Improvement (CMHI) staff, facilitating Medical Home Practice meetings for pediatric and family medicine teams, and attending Medical Home Learning Collaborative meetings, to represent SMS and to assist in facilitating learning sessions.

SMS will develop a new strategic plan to strengthen the care coordination model in community-based practices. Activities will include, but not be limited to, providing support and ongoing technical assistance (resource identification, problem solving, referrals, and linkages) to Medical Home Practice Care Coordinators and directly to CSHCN and their families. Assistance will be provided electronically, via telephone, and in person at medical office, home and school-based meetings. SMS, in collaboration with CMHI, will create written materials describing the Medical Home concept for statewide dissemination to professionals and families of CSHCN.

The strategic plan will also address the results of the 5-Year Needs Assessment indicating that the need for care coordination is not being met for those CSHCN receiving SSI who are also receiving Medicaid, and the need for increased care coordination for all medically and behaviorally complex CSHCN. (See the Needs Assessment for the reports.) Staff (Hoerbinger, Kaiser, and Ustinich) will develop protocols for increasing outreach and services targeting this population of CSHCN, including those treated in the Medical Home practices.

SMS will provide further education about the Medical Home Initiative by developing relationships with the NH Pediatric Society and NH Chapter of the American Academy of Family Practice. SMS will also pilot a payment mechanism for Title V support of some of the cost of providing care coordination services in a Medical Home pediatric practice.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				61.9	61.9
Annual Indicator			61.9	61.9	61.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.9	62.9	62.9	63.9	63.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The Title V CSHCN Health Care Financing Specialist (Ustinich) continued participation in state and regional policy discussions regarding CSHCN and the adequacy of their insurance. Activities of the program specialist included creation of the NH Insurance/Cost-of-Care survey instrument. The paper instrument duplicated selected questions from the National Survey of CSHCN 2001. (See Needs Assessment Appendix for instrument.)Preparation was made to conduct the survey of 1141 families of CSHNC receiving SSI for their own disability. (IB)

SMS staff (Ustinich) evaluated internal reporting mechanisms, identified functional problems with the SMS database and updated report formats. A major revision of the Section's Policy and Procedure Manual was undertaken, to improve the quality of service delivery, the integrity of data recording/reporting, and to support administrative functions.

A care coordinator continued to provide follow-up of SSI referral transmittals. This outreach, in part, assesses the family for SMS eligibility and insurance coverage status if not currently receiving Medicaid.

SMS staff (Bumbalo, Ustinich), in collaboration with NH Family Voices, implemented the work plan of the SMS/NH Family Voices Health Care Financing Group, to address two selected priorities. One is the increasing difficulty in obtaining adequate insurance for CSHCN and the other is the increasing demand for insurance coverage for durable medical equipment/non-pharmaceutical products. The group prepared for an FY 05 statewide conference on health care financing issues.

SMS disseminated an Issue Brief on Insurance Coverage and CSHCN to identified stakeholders and the public. The brief was the initial work product using the SLAITS data. The process of extracting and reporting on the variables for New Hampshire was technically difficult, and problems with analyzing the data correctly subsequently emerged. Revision of the issue brief was deferred pending technical assistance.

SMS followed the proceedings of the Commission on Insurance for Families of Children with Special Health Care Needs (formed by DHHS, reporting to the Governor and legislators). The report of this Commission addressed eligibility for the HC-CSD program in NH.

SMS participated in Cover the Uninsured Week, distributing informational cards in English and Spanish and other materials to the community-based care coordinators. The program specialist provided staff with resources for to youth with special health care needs, regarding insurance and SSI. A care coordinator (Kaiser) continued to provide follow-up to child SSI applicants referred to the Title V program by the SSA. This is an ongoing activity.

SMS (Bumbalo, Ustinich) authored an article accepted for publication by the Journal of Maternal and Child Health. The focus is on the adequacy of insurance for children with special health care needs and the impact of the child's condition on the family's finances, employment, and time. (Attached).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The SMS follow-up of SSI referral transmittals is ongoing and expansion of the service to Medicaid recipients is under discussion.				X
2. State-level data from the National Survey of Children with Special Health Care Needs 2001 is being disseminated via SMS materials designed for and provided to staff and stakeholders.				X
3. New Hampshire’s data from the National Survey of CSHCN was the basis of an article published in the MCH Journal. The article, “Economic Impact on Families Caring for CSHCN in New Hampshire”, is included in the Needs Assessment.				X
4. The health care financing survey was sent to over 1000 families of CSHCN receiving SSI for their own disability. The report of the results is included in the Needs Assessment, and the emergent issues are being discussed for policy considerations and				X
5. SMS again participated in Cover the Uninsured Week, and also provided staff with resources applicable to youth with special health care needs regarding insurance and SSI.				X
6. The SMS/NH Family Voices Health Care Financing Advisory Group conducted a conference on health care financing issues in the fall of 04, with 80 stakeholders participating. The group continues to meet and is				X

planning its work product for SFY06.				
7. Revision of materials related to policy and procedure, data collection, improving data integrity, data analysis and reporting of data is ongoing. Special meetings are being held to inform and train staff to implement revised procedures related to d				**X**
8. A new database to capture information from the SMS Information and Referral and Nurse on Duty calls/e-mails is being designed and will be operational in SFY06.				**X**
9.				
10.				

b. Current Activities

The SMS follow-up of SSI referral transmittals is ongoing and expansion of the service to Medicaid recipients is under discussion. SMS continues to assist stakeholders in addressing the adequacy of health insurance for CYSHCN. The process includes the dissemination of state-level data from the National Survey of Children with Special Health Care Needs 2001. SMS recognizes the need for improved access to data and statistical analysis, to articulate the status and emergent issues of CSHCN in New Hampshire. Research analysis was made available to SMS for projects related to the 5-year Needs Assessment; however, the Bureau-level lack of a trained data expert remains a challenge.

New Hampshire's data from the National Survey of CSHCN was analyzed by Renee Schwalberg, MPH, of Health Systems Research, Inc., for an article published in a special supplement of the MCH Journal. The article "Economic Impact on Families Caring for CSHCN in New Hampshire" is included in the Needs Assessment. The data indicate that the severity of a child's condition imposes a greater impact on the family than socioeconomic factors.

The health care financing survey was sent to over 1000 families of CSHCN receiving SSI for their own disability. The results are included in Needs Assessment, for policy considerations and in discussions of future initiatives. The primary conclusions are that NH CSHCN receiving SSI, compared to NH CSHCN in general, evidence a greater need for care coordination, a greater need for better-organized community systems, and a desire for more access to public/private funding. The findings also indicate that health care coverage alone is not sufficient to meet the mental health needs of this population.

SMS again participated in Cover the Uninsured Week, and also provided staff with resources applicable to youth with special health care needs regarding insurance and SSI. The SMS/NH Family Voices Health Care Financing Advisory Group conducted a conference on health care financing issues in the fall of 04, with 80 stakeholders participating. (Agenda attached) The goal is to assist families of CSHCN to increase their expertise in accessing resources related to the cost of health care. The group has begun a project involving the creation and dissemination of two booklets addressing this issue.

Revision of materials related to policy and procedure and data collection, analysis and reporting is ongoing. This activity, in part, focuses on articulating selected performance measures and desired outcomes in SMS materials, practices, contracts, and data entry protocols. Technical assistance is offered to care coordinators, community providers, and contractors. Issues related to the adequacy of insurance for CSHCN are interwoven with some aspects of these projects. For example, support is being provided to the Nutrition Network to assist in their efforts to be able to bill insurance for the services.

c. Plan for the Coming Year

NH data from the National Survey of CSHCN reports adequacy of insurance for 62% of families surveyed. The Date Resource Center for CSHCN indicates that 94% of NH CSHCN were insured; however, 38% of families did not meet all of the criteria for success for Outcome #3, adequacy of insurance, and 58% of families below 100% of the FPL did not meet the success threshold for this outcome. Of those reporting specific types of special health needs, 57% with children with functional limitations, 24% of those managed by prescription medications, 49% of those with an above routine need/use of services, and 36% of those with Rx meds and higher service use, combined, did not meet the success criteria for this outcome.

The SMS follow-up of SSI referral transmittals will continue. This outreach is to CSHCN who are not clients of SMS and who are not receiving Medicaid. The coordinator attempts to locate the families to ascertain the need/eligibility for SMS services. The family is sent the appropriate information, enrolled, referred, or discharged as indicated, and provided further follow-up if needed. The status of interaction between the staff/contractors and the families of CSHCN receiving SSI for their own disability needs further evaluation. Over 500 child SSI application transmittals pass through the SMS office annually; however, there is no central point of documentation of the determination and only limited outreach to this group. The results of the 2004 CSHCN-SSI survey indicate that the need for care coordination is greater for CSHCN receiving SSI who are also receiving Medicaid. Staff (Hoerbinger, Kaiser, and Ustinich) plan to develop an effective protocol for enhancing the capacity of SMS to increase the provision of care coordination to all CSHCN receiving SSI, including those receiving Medicaid.

The Health Care Financing Specialist (Ustinich) will participate in activities supporting SPM #8, addressing mental health and the development of a State Plan to integrate mental health services with primary care practices, and will participate in activities supporting SPM# 10, addressing workforce development of trained respite/childcare providers for medically/behaviorally complex CSHCN. The program specialist will continue facilitation of the SMS/NH FV Health Care Financing Advisory Group. The work product for SFY 06 will include materials on how to increase family access to resources which might pay for medical and non-medical health-related services and items that families are either paying for out-of-pocket or going without.

Staff (Ustinich) will increase SMS participation in Cover the Uninsured Week and will increase the SMS web-based library of materials for and about CYSHCN. This latter endeavor has been made a priority for SFY06. Part of this effort will involve the updating of existing materials and the creation of new materials. Improving data collection and reporting will remain a priority.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				78.4	78.4

Annual Indicator			78.4	78.4	78.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.4	79.4	79.4	80.4	80.4

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The Nutrition Feeding and Swallowing Program (NFSP) developed a plan for cost sharing. SMS prepared an RFP for administration and billing of NFS services that would expand community-based services, however the project was not funded. The Diabetes Pump Start program was deferred due to the lack of staff at the Hitchcock Clinic (Manchester). The NFSP staff offered regional workshops for families of children with autism, "Nourishing Your Child with Autism". NFSP contractors presented "Gastro-intestinal Concerns" to the Visiting Nurses Associations.

Community-based coordinators piloted the Transition Questionnaire. A community-based coordinator (Kinsey) for Rockingham and Strafford counties was hired in January 04. The dental health consultant held a forum with SMS care coordinators and NH Family Voices, and a protocol sheet for obtaining dental services was developed. Continuing education sponsorship included: a LEND /SMS Conference on Differential Diagnosis: Mental/ Behavioral Health, the SMS/ Interim Home Health Care Conference "Enhancing Clinical Competencies", and the SMS Neuromotor Program annual meeting "Focus on Spasticity Management".

Monthly continuing education meetings were offered to community-based coordinators. Neuromotor coordinator (Clark) at Child Health Services resigned; a new coordinator (Burgess) was hired. A new coordinator for the Neuromotor state-based position (Concord) was hired (Collins). Equipment bank protocol development considered a rental option for Medicaid reimbursement. The Neuromotor Clinic utilized the Transition Questionnaire and used transition-tracking sheets with the families. The DHMC NM clinic offered Botox injections and oral medication treatment for spasticity management.

One contracted nutritionist (Scott) offered outreach visits statewide to families of newborn infants with cleft lip and palate. The private multidisciplinary team in the Manchester clinic discontinued services; clients were referred to the DHMC cranial facial program. SMS staff (Cahill) attended Spina Bifida clinic monthly and provided coordination services. SMS offered financial assistance to cystic fibrosis clients, and transition services. The pediatric CF population was provided nutrition services that CF Foundation mandated through collaboration with the SMS nutrition network. The NM Perioperative Protocol received an Excellence in

Clinical Scholarship Award from the National Society of Pediatric Nurses. The NH Autism Task force issued its report with assessment and intervention recommendations. One nurse coordinator (Landry) completed LEND training. SMS nursing staff offered home-based assessments and recommendations of children's nursing care needs for Medicaid. Two coordinator positions remained unfilled. The program manager (McCann) retired in 2004 and the vacant position was ‘frozen'.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A nutritionist/diabetic educator participates at Diabetes Camp providing training opportunities for DHMC medical residents in pediatrics and family medicine and UNH Nutrition students and Dietetic Interns.				X
2. Training of new coordinators for community based care coordination and Neuromotor program continues.				X
3. Another state-based nurse (Collins) has completed the LEND program.				X
4. Recruitment for two state-based nursing positions continues.				X
5. Work with the NH LEND program is focusing on collaboration and training with emphasis on the National Performance Measures and medical home information				X
6. Enhanced support of the state’s Infant and Parent Mental Health teams is available through braided funding, to support a conference with a nationally recognized speaker.				X
7. Collaboration with the Medicaid program with nursing assessments to support case management continues.				X
8. Developing a protocol to offer care coordination services to a subpopulation of CSHCN who receive both SSI and Medicaid, to improve the organization of services for ease of use.				X
9.				
10.				

b. Current Activities

A nutritionist/diabetic educator participates at Diabetes Camp providing training opportunities for DHMC medical residents in pediatrics and family medicine and UNH Nutrition students and Dietetic Interns. A new contractor was hired to triage applications for the nutrition program as well as one to focus on special educational projects. Efforts are being intensified for SMS contracted nutritionists to collaborate with tertiary nutrition services, especially at DHMC metabolic program.

Training of new coordinators for community-based care coordination and Neuromotor program continues. Another state-based nurse (Collins) has completed the LEND program. Recruitment for two state-based nursing positions continues. The vacant program manager's position remains 'frozen'. There is no anticipated expansion in state funding to support increase of care coordination services. Community based-care coordinator for Rockingham and Strafford County resigned (Kinsey). A new hire is expected to start by July 1, 2005. Workloads of staff are evaluated periodically to determine essential services. Community-based care coordinators meet for continuing education monthly in community settings and include community partners for case reviews.

Work with the NH LEND program is focusing on collaboration and training with emphasis on the National Performance Measures and Medical Home information. Training and support has been offered to Child Health Services to enable billing, with specific training for coding care coordination. Enhanced support of the state's Infant and Parent Mental Health teams is available through braided funding, to support a conference with a nationally recognized speaker.

Plans to have the SMS brochure translated into Spanish continue. Family Voices completed the process of triaging and follow-up of clients in the discontinued Cleft Lip and Palate program to determine needs for care coordination, clinic services and/or financial assistance. Plans are under discussion to expand the outreach services to a subpopulation of CSHCN who receive SSI and have Medicaid, based on data emerging from the Needs Assessment. Collaboration with the Medicaid program with nursing assessments to support case management continues.

c. Plan for the Coming Year

According to the Data Resource Center for CSHCN, the National Survey of CSHCN results for NH (Outcome #5) indicate that 78% of NH respondents thought the community-based service systems were organized so families could use them easily. Among the respondents reporting an above routine need/use of services, and among those whose children experienced functional limitations, 30% of both groups did not think the services were organized for ease of use. Of those with insurance coverage, and of those with no current insurance, 22% of both groups did not think the services were organized for ease of use.

The Nutrition, Feeding and Swallowing Program (now contracted through Child Health Services (Manchester) will further develop its services in accordance with the CSHCN State Performance Measures and National Healthy People 2010 mission by developing: 1) a mechanism for cost sharing between state and private payers; 2) alternative service models for target CSHCN populations to increase access (e.g. parent education groups for children with identified medical conditions); 3) closing existing service gaps to increase access and to build capacity of quality specialty services for families of CSHCN (e.g. DHMC/SMS collaborative projects for Cystic Fibrosis and Pediatric Diabetes); 4) Increase the capacity of specialized pediatric nutrition services for CSHCN such as training of regional nutritionists, and dietetic interns at diabetes camp; 5) Coordinate specialty services systems for CSHCN to increase ease of use (e.g. development of multidisciplinary feeding team to serve CSHCN with complex nutritional and feeding/swallowing issues in a clinic setting). Pre operative review of care plans for children scheduled for extensive orthopedic surgery will include nutrition consultation with copies of care plans to primary care providers and the institution where surgery is performed. The goal of all pre-operative protocols is to coordinate community services.

A protocol to increase outreach to parents who apply for SSI for CSHCN, and who have Medicaid, will be developed by designated Coordinators and the Health Care Financing Specialist/SSI Liaison. Survey data indicated there was a need for SMS to determine the care coordination needs of this population. To further identify the level of care coordination of CSHCN in NH. The IDAHO or similar tool will be used by all agencies with care coordination. These activities would be pending a waiver and new staff recruitment at SMS. Comprehensive care coordination continues to be strengthened by SMS being active in new initiatives and groups within the State system of care.

Performance Measure 06: *The percentage of youth with special health care needs who received*

the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.9	5.9	6	6

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

SMS increased capacity to provide support and education services about transition to two populations of youth with special health care needs (YSHCN) and their families- those with spina bifida and those with neuromotor disabilities. Specific transition education materials were provided to other program care coordinators to use with their populations of youth. The goals and objectives of the Neuromotor Transition Project were met by developing a protocol to use in clinics. This includes clinic staff using the youth transition questionnaire titled "How Well Do You Manage Your Own Health Care" (developed in July 2003) with youth, as well as inclusion in the client record of the Health Care Transition Checklist, a tool for documentation about transition activities (developed in April 2004).

The Dartmouth-Hitchcock Medical Center Spina Bifida Program utilized the assessment materials SMS developed for the Neuromotor Program. Other transition efforts with this population included conducting a survey and providing individual education at clinics. A telephone survey of 19 families was conducted in June and July 2003 and the results helped determine how best to reach families and teens to talk about transition issues. Utilizing the Internet received favorable response as a potential educational and support tool since almost all the families have access, however no interactive site could be developed. The Spina Bifida Program website, launched February 04, began to meet this interest. This website includes a page about transition and links to on-line transition resources. There was continued interest in discussion/education about transition issues both during clinic and outside of the clinic visit.

SMS addressed the interests of families regarding transition by developing the role and activities of the NH SMS/Family Voices Youth Transition Advisory Group, comprised of parents, community-based family support professionals and staff. This group met quarterly and assisted the in-house committee by reviewing transition related educational materials and tools. The group produced a SMS/FV brochure, titled "Growing Up" about youth health care transition for parents. (Attached).

SMS staff continued to participate in collaborative efforts to improve statewide transition services for YSHCN. SMS was among four agencies that submitted a proposal to the National Library of Medicine, titled "The Adolescent Chronic Conditions Health Information Project". The submission was not funded, however the principal investigators were invited to re-submit. SMS participated in the development of the NH Adolescent Health Strategic Plan, which was headed by the New Hampshire Bureau of MCH. SMS staff were members of a working group on Transition in the New Hampshire Department of Education and brought a perspective on health to this process, by promoting family-centered, comprehensive and interagency approaches to secondary transition activities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate and coordinate the activities of the Youth Health Care Transition Project (YHCT).				X
2. The YHCT Project is working with selected pediatric practices to identify and develop the strategies and protocols necessary to transition selected youth to adult health care services.				X
3. Continue meetings of the Youth Health Care Transition Coalition.				X
4. Provide health care transition services to youth in SMS programs and in the Spina Bifida clinic population.				X
5. Continue the Transition Workgroup meetings to identify tools and strategies to use in clinic and on home visits and to support the educational activities of staff.				X
6. Participate in collaborative educational programs about transition for families, youth, and professionals.				X
7. Work with pediatric practices to promote increased awareness of the health care transition process by utilizing targeted mailings and distributing materials to members of the NH Pediatric Society.				X
8. Distribute health care transition resource materials, including the Health Care Transition Manual to staff and outside agencies.				X
9. Distribute the brochure “Growing Up” to families of CYSHCN.				X
10. Coordinate transition activities with the Center for Medical Home Improvement.				X

b. Current Activities

Special Medical Services submitted a proposal for the Champions for Progress Incentive Award offered through the Early Intervention Research Institute at Utah State University, and was awarded funds to conduct a project. The overall goal of the Youth Health Care Transition Project (Youth HCT Project) is to facilitate and coordinate activities that foster private/public partnerships to move forward the system of care for successful health care transition. SMS is

working with selected pediatric practices to identify and develop the strategies and protocols necessary to transition selected youth to adult health care services. We have piloted "readiness for transition" interviews; health care management self-assessment tools and participant care plans. A steering committee, the Youth HCT Project Coalition, has been created that reviews ongoing activities and will develop a statewide plan to disseminate these strategies and protocols, in order to promote improved transition practices.

Care coordinators from SMS and the Spina Bifida program, the Partners in Health family support coordinators, as well as coordinators in medical practices; such as the Partners for Chronic Care Project and the Medical Home practices all need information and resources about how to support health care transition for youth. SMS is disseminating the Health Care Transition Manual to selected coordinators. The manual contains educational and resource materials about transition that have been reviewed and/or developed by members of the Neuromotor Transition Project. This group has now become the Transition Work Group. It is comprised of care coordinators and neuromotor clinic staff who meet to identify tools and strategies to use in clinics and on home visits, including ways to access primary care providers in both the pediatric and adult sectors. One new tool developed this year is the Health Care Transition Summary and Adult Care Plan.

SMS participated in an interagency education project for families and teens about all aspects of transition with our focus on health care. SMS staff also provided transition information packets and a Bulletin Board to attendees at the NH Pediatric Society Spring meeting.

The Youth Health Care Transition (HCT) Project Coalition replaced the Youth Transition Advisory Group. This was a very helpful group in the early phase of SMS transition activities, e.g. the "Growing Up" brochure developed by the group has been an excellent educational tool. In addition to direct distribution to families, this brochure was included in the Youth HCT Project recruitment letter to pediatricians.

SMS is currently the only New Hampshire state agency that is focusing on the health care aspects of transition for Youth with Special Health Care Needs. The Center for Medical Home Improvement is also working on transition with selected pediatric practices and we will coordinate our efforts.

c. Plan for the Coming Year

The SMS priority regarding the transition of YSHCN to adult life will be to carry out the objectives of the Youth Health Care Transition Project, which will end in June 2006. The objectives are: 1) to work with selected practices to develop the strategies, methods, and protocols necessary to transition a sample of six YSHCN from pediatric to adult health care, and 2) to develop a steering committee of health care partners to coordinate, integrate and promote improved transition practices throughout the state. SMS plans to recruit an additional youth in each of the three practices currently involved with the project. One of the protocols under development describes the Stages of the Health Care Transition Process. One of the methods is to identify ‘state-of-the-art' preventive health care and education guidelines for adult health care based on participant diagnoses.

SMS staff plan to continue collaboration with the STAR program, Partners in Health, Granite State Independent Living and NH Family Voices to provide family/teen transition education workshops. SMS is part of a group planning a statewide conference on transition for professionals, which will occur in November 2006.

SMS staff plan to evaluate the use of the materials in the Health Care Transition Manuals. The Neuromotor Program will continue to refine its transition education approaches and these will be shared with all SMS programs.

Activities that had been included as part of the FY05 State Performance Measure (retired) on transition will be continued under the Champions for Progress Incentive Award and will be included in NPM #6, including efforts to identify and work with interested adult health care providers and publishing an Issue Brief on Transition to be disseminated to parent and professional groups.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	85	85	80	80
Annual Indicator	80.0	80.0	79.6	80.9	83.9
Numerator	11741	12042	11981	12177	12628
Denominator	14676	15052	15052	15052	15052
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

Notes - 2002

The numerator was obtained by using the CDC National Immunization Survey rate for NH and applying it to the denominator. Denominator is two-year olds in NH from the 2000 census.

Notes - 2003

The numerator was obtained by using the most recent CDC National Immunization Survey rate for NH (Q3/2002-Q2/2003) available from the NH Immunization Program, and applying it to the denominator. The denominator is two year olds in NH from the 2000 census.

Notes - 2004

Future objectives have been reviewed due to "data alert" and are appropriate given fluctuating results from year to year.

a. Last Year's Accomplishments

Collaboration with the NH Immunization Program continued. The Immunization Program presented changes in immunization policy or administration to the MCH contract agencies at the fall and spring Child Health Program Coordinators' meetings and via mailings. (IB)
MCH contract agencies submitted their completed FY'03 workplans in fall ‘03 that included successful strategies or obstacles to achieving their target for the national performance measure of adequately immunized two year olds. FY'05 workplans were submitted by May

2004. The workplan performance measure definitions were revised, reviewed at the spring '04 MCH Coordinators' Meeting, and a workshop was held in May on how to develop meaningful workplans. For consistency and continuity, agencies will now be requested to use their most recent year's CASA result for the performance measure result. (IB)
MCH, as part of the larger OCPH, piloted a performance management-based multi-program team site visit to Avis Goodwin Community Health Center, a state and federally funded primary care center. Review included successful efforts to improve its immunization-related performance measure. (IB)
Two MCH Title V contract agencies hosted CDC Immunization Training Teleconferences on behalf of the NH Immunization Program. (PB)
The MCH Home Visiting contract agencies educated families about the importance of getting their children immunized on time and will assist families, as needed, to get to their health care providers. (D)
The MCH Healthy Child Care New Hampshire Project included in its training to health consultants, the importance of assuring timely age appropriate immunizations in children cared for by child care providers, particularly those children in Title XX funded child care centers. (IP, PB)
The MCH and the NH Immunization Program participated in meetings to review competitive bid applications and the grantees progress in conducting community focus groups in Nashua to better learn about obstacles to obtaining immunizations, especially for racial and ethnic minorities. MCH was interested in learning about barriers to obtaining health care for children in its Title V funded child health programs. Findings will be shared to improve access. (PB)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the NH Immunization Program on any state or local activities.				X
2. Communicate immunization policy changes to Title V-funded agencies.				X
3. Collaborate with the NH Immunization Program in using CASA results from Title V-funded agencies for quality assurance activities including site visits and performance measures.				X
4. Discuss the findings of the NH Immunization Program’s report of the community focus groups in Nashua to determine how access and utilization of care, including immunizations, for all children but especially those from racial and ethnic minorities, ca				X
5. Require the MCH Home Visiting contract agencies to educate families about immunizations.				X
6. Include immunizations in the training and information updates of Healthy Child Care New Hampshire child care health consultants.				X
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration with the NH Immunization Program continued. The Immunization Program presented changes in immunization policy or administration to the MCH contract agencies at

the fall and spring Child Health Program Coordinators' meetings and via mailings. Included in the spring '05 meeting was a request for participation from MCH contract agency staff to assist in planning how best to capture the middle school and adolescent populations with the soon to be released new vaccines intended for these age group. (IB)
The FY04 completed agency workplans were reviewed in fall '04, and the FY06 workplans were submitted and commented upon in spring '05. Immunization of two year olds continues to be a required workplan performance measure (IB).
With the addition of a Quality Assurance Nurse Consultant, MCH has put an increased emphasis on conducting site visits to its primary care and child health direct care agencies. Tracking and follow up of missed immunizations and follow up on recommendations from the NH Immunization's CASA site visits are included. A multi-program DHHS team performance management based site visit to Ammonoosuc Community Health Services, a state and 330-funded primary care center, was conducted in May, in which staff from the NH WIC and Immunization Programs participated. Included in the discussion was how WIC could better access the electronic medical record's immunization data of the children enrolled at the community health center. Earlier in the month, a multi-program MCH clinical site visit involving chart reviews, was conducted at Coos County Family Health Services, another state and federally funded community health center. Included in the discussion was how to utilize the electronic medical record for immunization documentation requirements without necessitating a paper chart. (IB)
MCH contract agencies continued to host CDC Immunization Training Teleconferences on behalf of the NH Immunization Program. (PB)
The MCH Home Visiting contract agencies continued to educate families about the importance of getting their children immunized on time and assist families, as needed, to get to their health care providers. (D)
The NH Immunization Program's report of the community focus groups in Nashua was completed and released. (IB)
Consultant staff contracted hired to assist in coordinating the Early Childhood Comprehensive Systems grant will include activities which assure timely age appropriate immunizations for all of the state's early childhood population, with particular emphasis on those children in centers receiving consultation from MCH trained health consultants and especially in Title XX funded child care centers. (IP, PB)
A daylong orientation session was held for new staff of MCH contract agencies which included information on the required immunization schedule and immunization-related quality improvement activities such as the immunization performance measure in agency workplans, site visits, and the CASA audit. (IB)

c. Plan for the Coming Year

The NH Immunization Program's report of the community focus groups in Nashua will be reviewed with discussion on how best to utilize findings to improve access to care, including immunizations, for all children but especially those from racial and ethnic minorities. As New Hampshire is seeing an increase in foreign populations, this is of increasing importance. (PB)
MCH contract agencies will submit their completed FY'05 workplans in Fall '05, which will be evaluated for success in reaching or failure to achieve the desired target, including successful immunization of two year olds. In spring '06, the agencies will submit their FY07 workplans. (IB)
Additional site visits to the primary care centers that have not received visits within the past few years, or those about which MCH has concerns, will continue. With the addition of an MCH Adolescent Health Program Coordinator, collaboration with the NH Immunization Program will increase as vaccines specifically for adolescents become available. (IB).
Immunization-related activities of the Healthy Child Care New Hampshire Project, the Home Visiting Program, and the Early Childhood Comprehensive Systems grant will continue. (PB, IB)

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	12	12	12	12
Annual Indicator	10.2	10.3	8.5	7.4	
Numerator	258	264	222	199	
Denominator	25292	25540	26232	26864	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Notes - 2002

1) Data is from calendar year 2001 vital records. 2002 data is not available.

2) 2002 data will not be available until the next grant application period.

Notes - 2003

Calendar year 2003 vital records data is not yet available. This data will be available for next year's application.

Notes - 2004

CY04 data will not be available until next year.

Future objectives have been reviewed due to "data alert", and are appropriate.

a. Last Year's Accomplishments

Teen clinics continued to offer teen-friendly services that are confidential, affordable, available during weekend or evening hours on a walk-in basis, and staffed by both professional staff and teen peer educators. These sites continued to provide extensive pregnancy prevention, counseling and education to teen clients. The Teen Clinic programs have expanded to 5 agencies providing 12 teen clinics. Performance measures include numbers of teens served, the availability of emergency contraception and the effectiveness of community educators in increasing awareness of family planning services. (D,E)

The Abstinence Education project continued with a media campaign targeted to 10-14 year olds as well as providing abstinence-only education through schools and community based agencies. (P)

The Abstinence Task Force, appointed by the Commissioner of DHHS, completed a full review of the Abstinence Education Program and made final recommendations for future initiatives to Commissioner Stephen. (P)

Activities to implement the Adolescent Health Strategic Planning Project recommendations began last year by our external partners including the UNH Center on Adolescence, formerly the Adolescent Resource Center (ARC), and others. The Center on Adolescence is a University based center that collaborated actively on the development of the Adolescent Health Strategic Plan. In the last two years the center's activities focused on advocating for a youth development approach to adolescent health, and development of a resource outlining services available to New Hampshire's youth.

Plans to develop regional adolescent health advisory groups, and contracting for the development of a web-based adolescent health data set that would have allowed communities to access national and state objectives, including the reduction of teen births, were not carried out due to staffing shortages and a change in focus of the web-based data query tool.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training NH primary care providers in MCH-funded agencies and other settings on clinical best practices and adolescent medicine.			X	X
2. Continue and extend teen pregnancy prevention education and promotion of responsible sexual behavior.		X		X
3. Continue and extend support to agencies implementing the Abstinence-only Education program.		X		X
4. In partnership with youth serving agencies and organizations, other state agencies, UNH Cooperative Extension, UNH Center on Adolescent and other stakeholders establish Youth Advisory Council.			X	X
5. Continue our involvement in the new partnership with the Department of Education and contribute to the development of a Coordinated School Health Plan.				X
6. Disseminate the strategic plan document to main stakeholders and encourage them to use the document and implement the concrete action steps developed.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities

Community education activities continue and are expected to impact pregnancy through the implementation of evidence-based teen pregnancy prevention curricula in schools and youth serving agencies; through targeted teen pregnancy prevention provided by the community educators using their choice of five activities (parent/child communication, male involvement, contraception presentations, marketing/outreach, and peer education).
Additionally, the family planning program continues to promote the implementation of three curricula in middle and high schools. The program is planning an evaluation at the end of the year to measure the success of these curricula.

We were not able to expand community education activities through further TANF collaboration as planned. Additionally, financial constraints didn't allow the implementation of the comprehensive youth development project based on the Carerra Model, a program proven to

reduce teen pregnancy (D,I,E).

In addition to comprehensive sexuality education programming, an abstinence-only education project has been implemented in a dozen communities through contracts with 9 agencies funded by the 510 Abstinence Education Program. School and community based education sessions are presented, including middle schools in Manchester, New Hampshire's largest city.

The Adolescent Health Strategic Plan was released this year after going through the full internal review and approval process, and is posted on the DHHS web site. Although the plan's release took longer than expected, we anticipate that the document will serve as a reference for agencies and organizations involved in activities related to adolescent health in New Hampshire. We will promote shared use of the document among our partners to build upon the concrete action plans and recommendations developed during the Adolescent Health Summit hosted in October 2003 as a follow-up to the Adolescent Health Strategic Plan project.

c. Plan for the Coming Year

MCH will continue to promote and support community education activities that have the potential to impact teen pregnancy and will favor evidence-based programs through contracts with youth serving agencies; and through targeted teen pregnancy prevention provided by Family Planning Program (FPP) community educators using their choice of five activities (parent/child communication, male involvement, contraception presentations, marketing/outreach, and peer education).

Additionally, the FPP will continue to promote implementation of the curriculum project in middle and high schools and will use the results of the evaluation to be conducted at the end of this year to make adjustments if needed.

The Abstinence Education program will continue through contracted agencies and will be expanded as funding allows. An evaluation of the education curriculum delivery will be conducted and results will be used to improve educational activities.

We will continue to collaborate with UNH Center on Adolescence and other partners to establish a statewide Adolescent Health Network to advocate for a positive youth development approach to health related programming and to implement recommendations of the Strategic Plan throughout New Hampshire communities. (I,P)

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14	46	47.5	46	46
Annual Indicator	38.2	45.9	45.9	45.9	42.4
Numerator	1863	188	188	188	249

Denominator	4875	410	410	410	587
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	42.4	42.4	42.4	44	44

Notes - 2002

Statewide oral health data for measures #9 and 10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey will be conducted for the second time in the spring of 2004 and thereafter every three years. The Oral Health Program will not know until the 2004 survey results are analyzed if we have achieved our objective. The 2001 Oral Health Survey of Third Grade Students indicated that 46% of third graders had dental sealants on at least one permanent tooth and that that 22% of third graders had untreated decay. To reach the Healthy New Hampshire 2010 goal of 60% of third graders with sealants, each year an additional 1.5% students will need to receive sealants. To approximate the national Healthy People 2010 objective and reduce the percent of students with untreated decay to 19% by 2010, an additional .4 % of students each year must show reduced levels of untreated decay. Results of the 2004 statewide survey will indicate if we are on track to achieve the 2010 goals.

Notes - 2003

Statewide oral health data for NPM #9 and SPM #10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey has been conducted for the second time in the spring of 2004 and will be repeated every three years. The 2001 Oral Health Survey of Third Grade Students indicated that 46% of third graders had dental sealants on at least one permanent tooth and that 22% of third graders had untreated decay.

Given state budget constraints, the performance measure objectives for 2005-2008 have been adjusted downward.

Notes - 2004

Statewide oral health data for NPM #9 and SPM #10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey was conducted for the second time in the spring of 2004 and will be repeated every three years.

Given state budget constraints, the performance measure objectives for 2005-2009 have been adjusted.

a. Last Year's Accomplishments

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state-funded programs to the statewide surveillance system. The CDC epidemiologist and OHP manager presented the ‘03 data to hygienists from 16 school-based dental programs. (IB, ES, PBS)
The OHP collaborated with the CDC epidemiologist to publish New Hampshire Oral Health Data, 2003 reporting on all 8 national oral health indicators. (IB, PBS, ES)
The OHP has conducted the second Oral Health Survey of Third Grade Students using the ASTDD model to screen children for the presence of dental sealants. (IB, ES, PBS, DS).
The OHP has collaborated with the Endowment for Health to fund a year-long planning grant to develop a sustainable statewide sealant project and an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).
The OHP has collaborated with NH Head Start to convene a statewide Head Start Oral Health Forum. In collaboration with New England dental directors and Region I administrators, the OHP will convene a regional Head Start Oral Health Forum in June '04.

The OHP collaborated with Home Visiting New Hampshire to secure HRSA funds to support oral health activities in 19 HVNH programs. (IB, PBS, ES)
The OHP continues to support municipal water fluoridation in spite of the court's ruling against the regional distribution of fluoridated water without an affirmative vote by each affected community. (IB, PBS)
The Northeast Delta Dental (NEDD) program, a voluntary Medicaid Managed Care program with a prepaid dental benefit, was terminated. To compensate for the loss of the NEDD program, the new Dental Director implemented significant dental reimbursement increases and made personal contacts with established Medicaid providers and potential Medicaid provider enrollees. (IB, ES, PBS, DS)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate to find treatment for clients.		X	X	X
2. Collaborating with Medicaid and EFH, open new dental programs in Coos an Grafton counties, Sullivan County and in the Rochester region.	X	X	X	X
3. Continue collaboration with EFH in year two of the NH Statewide Sealant Project applying sealants on both second and third graders in three additional pilot schools.	X	X	X	X
4. Collaborate with Maine and Massachusetts on the implementation of the “Watch Your Mouth” campaign, using Boston media markets to increase public perception of the value of good oral health as a component of overall health.		X	X	X
5. Collaborating with CHAN, continue working to integrate oral health assessment into medical care by educating providers, patients, and parents while implementing the aggressive use of evidence-based preventive interventions.	X	X	X	X
6. Collaborating with the NH Loan Repayment Program, recruit dentists for underserved areas of the state.		X	X	X
7. Collaborating with the Bureau of Elderly and Adult Services, initiate a program to provide oral health services for seniors.	X	X	X	X
8. Collaborate with Southern NH AHEC and the Minority Health Coalition to inventory oral health educational materials, select the best and “brand” them for the NH market.		X	X	X
9. Collaborate with MCH partners in the ECCS Grant including oral health objectives.		X	X	X
10.				

b. Current Activities

The OHP anticipates that the Endowment for Health (EFH) will fund the implementation of the planned statewide sealant project that will increase the amount of protective sealants on NH's high-risk children. (IB, PBS, ES, DS)
The OHP will collaborate with the CDC epidemiologist to publish the results of the second Oral Health Survey of Third Grade Students. (IB, PBS, ES)
The OHP will collaborate with EFH to implement the "Watch Your Mouth" oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)
The OHP will collaborate with the Area Health Education Centers (AHEC) to provide oral health

trainings for prenatal medical providers to educate them about the transmission of oral disease between mothers and infants and the importance of good oral health for their high-risk patients.
In collaboration with the Medicaid program and the Endowment for Health, the OHP anticipates the opening of 3 new dental centers in CHC's (Strafford County, Berlin and Littleton), 2 new dental centers clinics in hospitals (Weeks and Alice Peck Day) and the expansion of two urban dental centers in Manchester and Nashua.

c. Plan for the Coming Year

The OHP will continue working with the Dental Director and Medicaid Program to inform and educate the dental professional community about programmatic improvements and significant increases in Medicaid reimbursements with the goal of increasing the number of enrolled dental providers. (IB, ES, PBS, DS)
The OHP will continue collaborating with the Endowment for Health and the NH Dental Society in year two of the NH Statewide Sealant Project to develop a sustainable statewide school-based sealant program. (IB, PBS, ES, DS).
In cooperation with the newly hired chronic disease epidemiologist, OHP will collect, analyze, and add new data from 16 state-funded oral health programs to the statewide surveillance system. (IB, PBS, ES)
The OHP will collaborate with the newly hired chronic disease epidemiologist to publish New Hampshire Oral Health Data, 2004-2005 reporting on all 8 national oral health indicators, including an indicator on sealants (IB, PBS, ES)
The OHP will continue collaborating with oral health advocates implementing activities outlined in the New Hampshire Oral Health Plan: A Framework for Action to improve the oral health status of all NH residents (IB, PBS, ES)
The OHP will continue collaborating with Northeast Delta Dental to complete an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).
The OHP will collaborate with the Endowment for Health and other participants in trainings, the development of media materials, and in all aspects of the launching of the "Watch Your Mouth" oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)
The OHP will work with the Area Health Education Centers (AHEC) and the Minority Health Coalition on the State Oral Health Collaborative Systems Grant (SOHCS) to develop a reference library of NH "branded"materials for prenatal and pediatric medical providers to educate them about the transmission of oral disease between mothers and infants and the importance of good oral health for their high-risk patients. (IB, ES, PBS)
In collaboration with the Medicaid program and the Endowment for Health, the OHP anticipates the opening of new dental centers in the city of Manchester, Sullivan County and Carroll County and a new school-based sealant program in Rochester and surrounding schools.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	2	28	28	36	36

Objective					
Annual Indicator	2.3	28	32	32	32
Numerator	6				
Denominator	257477				
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	36	36	36	36	36

Notes - 2002

1) Data is calendar year 2001 vital records. 2002 is not available.

2) 2002 vital records data will not be available until the next grant application period.

The 2001 indicator for this measure was calculated using the Standardized Ratio methodology, as described in the block grant guidance. Raw data is as follows:

NH numerator: 3
NH denominator: 260285
U.S. rate: 4.04

U.S. data source: http://webapp.cdc.gov/sasweb/ncipc/mortrate10.html

Notes - 2003

1) Calendar year 2003 vital records is not available. It will be available for the 2006 application.

2) The 2002 indicator for this measure was calculated using the Standard Ratio methodology, as described in the block grant guidance. Raw data is as follows:

NH numerator: 4
NH denominator: 263093
U.S. rate: 4.79

U.S. data source: http://webapp.cdc.gov/sasweb/ncipc/mortrate10.html

The objectives for 2003-2008 have been adjusted upward to reflect expected fluctuations in the Standard Ratio due to an historic variation in the number of deaths.

Notes - 2004

1) Calendar year 2003 and 2004 vital records is not available. It will be available for the 2006 application.

2) The 2002 indicator for this measure was calculated using the Standard Ratio methodology, as described in the block grant guidance. Raw data is as follows:

NH numerator: 4
NH denominator: 263093
U.S. rate: 4.79

U.S. data source: http://webapp.cdc.gov/sasweb/ncipc/mortrate10.html

The objectives for 2003-2008 have been adjusted upward to reflect expected fluctuations in the Standard Ratio due to an historic variation in the number of deaths.

a. Last Year's Accomplishments

Certified workforce: A survey of existing technicians and inspection stations determined that the Lakes Region was underserved and lacking in CPS services. Training followed where 23 technicians completed the course. A technician update was held to coincide with the changing of technician certification from AAA to National SAFEKIDS. At the end of last year, there were 186 people trained in the certification courses. (I)
Booster Seat Coalition: A new booster seat law was passed and signed by the governor in September of 2003, taking effect on January 1, 2004. The law states that children need to be in appropriate child seats up to the age of 6 or 55 inches. To make the public aware, CPS created a flier in the Child Health Month packet and distributed additional yardstick posters, containing a ruler and an explanation of the law. These materials were sent out to many different organizations. Public service announcements were produced. To evaluate the effectiveness of the above efforts, the NH Survey Center, at the University of New Hampshire, was utilized an omnibus surveys. They reported that 56% of respondents had heard of the new booster seat law. (I)
Inspection stations and Check Up Events: There were 18 inspection stations in New Hampshire last year that continued to do the bulk of car seat inspections (714 seats checked. However, 18 car seat events also took place last year, with 436 seats checked. Improvements were made to 87% of the total amount of seats checked. (P)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train and certify child passenger safety technicians and instructors.				X
2. Continue to promote and distribute booster, convertible, and infant seats.			X	
3. Increase the number of inspection stations.				X
4. Pair technicians at inspection stations with mentors who will be CPS instructors.				X
5. Educate hospital providers regarding car seats for children with special needs.			X	
6. Continue work on proposed adult seat belt legislation.				X
7. Facilitate car seat checks, with a built in six- week re-check for all participants.			X	
8.				
9.				
10.				

b. Current Activities

Certified workforce: Work is taking place with partners to ensure an adequate supply of car seats. Two technician trainings are being planned for this year. (P)
Special Needs Training: Twelve certified car seat technicians were recently trained in special needs seats. One instructor became certified to teach special needs training. (I)
Policy: A secondary seat belt law was introduced into legislation. This bill was defeated. (I)

c. Plan for the Coming Year

Certified Workforce: In order to increase technical skills, technicians at inspection stations will be paired with a mentor who will be a CPS instructor. (I)
Special Needs Training: Workshops are planned at hospitals around the state to educate their staff on the use and availability of special needs seats. (P)
Inspection stations and Check Up Events: Several car seat events will take place where initial surveys of participants on correct utilization of seats will be done. Six weeks later, these same participants will come back for a re-check of their seats to determine how much has been retained. (P)

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	69	69	66	66.5	66.5
Annual Indicator	63.3	67.5	67.6	65.3	
Numerator	8855	9480	9427	9059	
Denominator	13987	14052	13943	13875	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66.5	66.5	66.5	66.5	66.5

Notes - 2002

The numerator is newborn screening program data, using information from filter papers. The numerator is those exclusively breastfeeding. The denominator is the number of NH occurent births.

Notes - 2003

The numerator is newborn screening CY2003 data, information from filter papers. It includes only those exclusively breastfeeding. The denominator is the number of occurent births.

Notes - 2004

CY04 birth data will be available next year.

a. Last Year's Accomplishments

MCH staff continued to work with WIC to support breastfeeding education activities including dissemination of breastfeeding information to Title V funded Child Health, Primary Care, Prenatal and Home Visiting agencies, and sharing information from medical journals on breastfeeding issues with the WIC Breastfeeding Promotion Consultant. (IB)
The MCH SIDS Program Coordinator continued to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices including WIC nutritionists (June '04), child care providers (fall '03, spring'04), early childhood

education college students (spring '04), and hospital perinatal nurse managers (June '04). At the June '04 Child Fatality Review Committee Meeting, focusing on the issue of breastfeeding, bedsharing, and accidental asphyxiation deaths, two community breastfeeding advocates were included. A recommendation was made by the committee for public health to develop a handout in collaboration with the NH Breastfeeding Task Force, on informing parents about potential danger of bedsharing. (IB, PB)
MCH helped sponsor the NH Breastfeeding Coalition's annual June '04 conference that featured Dr. James McKenna, a strong breastfeeding proponent. (IB)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with WIC on activities to enhance breastfeeding in MCH Title V-funded agencies.			X	X
2. Meet quarterly with WIC Breastfeeding Consultant to improve collaboration.				X
3. Promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices.			X	
4. Complete and disseminate bedsharing handout.			X	X
5. Work with the Newborn Screening Program to educate hospitals on their breastfeeding rates based on newborn screening filter paper information.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH staff continues to work with WIC to support breastfeeding education activities including dissemination of Breastfeeding information to Title V funded Child Health, Primary Care, Prenatal and Home Visiting agencies, encouraging observation of August as Breastfeeding Promotion Month, and inviting the WIC Breastfeeding Promotion Consultant to present mini in-services at the MCH Coordinators' meeting for Title V funded Prenatal and Child Health Program Coordinators, and to Home Visiting Program Coordinators' Meetings and/or training for home visitors. (IB, PB)
The MCH SIDS Program Coordinator continues to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. Presentations and workshops were made to WIC Breastfeeding Consultants, child care providers, hospital staff, and pediatric nurses, sponsored by various organizations. (PB)
A handout on safe sleeping for parents on bedsharing, especially those who breastfeed, in follow up to the June 04 NH Child Fatality Review Committee recommendation, was drafted by a workgroup of representatives from MCH, the Injury Prevention Center, WIC, and the NH Breastfeeding Task Force. (PB)

c. Plan for the Coming Year

The MCH Child Health Nurse Consultant will continue to collaborate on activities that will enhance breastfeeding among the women enrolled in the Title V-funded MCH agencies

including the home visiting programs and the child care consultants of the Healthy Child Care New Hampshire project. Quarterly meetings between the MCH Child Health Nurse Consultant and the WIC Breastfeeding Consultant are planned to improve communication. (IB)
The MCH SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)
The bedsharing handout will be finalized and distributed widely statewide, coinciding with the recognition of October as national SIDS Awareness Month. (PB)
The MCH Newborn Screening Program Coordinator will provide feedback to the state's hospitals with birth facilities on feeding patterns of its infants born the previous year, as indicated on the information section of the newborn metabolic screening program's filter paper. As this is currently the only statewide breastfeeding data available, it is hoped that the feedback will serve as a quality assurance activity as well as providing incentive to each facility to improve their breastfeeding rates. (IB)

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	26	70	85	85
Annual Indicator	23.7	65.4	82.4	91.2	
Numerator	3318	9187	11486	12655	
Denominator	13987	14052	13943	13875	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	96	96	96	96

Notes - 2002
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2003
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2004
CY04 birth data will be available next year.

Objectives have been increased, although it was not possible to change 2004.

a. Last Year's Accomplishments

The name of the program was changed to Early Hearing Detection and Intervention (EHDI) Program to be consistent with other programs nationally and to more accurately reflect the

activities of the program. (IB)
Screening Programs: The EHDI Program staff continued to encourage hospitals without newborn hearing screening to develop programs. A telephone survey conducted in December 2003 revealed that one hospital had closed its maternity unit. Dartmouth Hitchcock Medical Center changed from high risk only to universal newborn hearing screening. Two additional hospitals started newborn hearing screening programs. By December 2003, 23 out of 24 hospitals with birth facilities had newborn hearing screening programs. (PB)
Advisory Committee: Activities of the EHDI Advisory Committee members included discussion of the development of additional pediatric diagnostic centers, education of physicians about the EHDI process, implementation of the Auris tracking system and use of the data available in the tracking system. (IB)
Tracking System: Hospital users and the EHDI Program staff learned to use the Auris tracking system and collection of data for pilot testing began in September 2003. The data linkages between birth data and the Auris tracking system were established and began testing in November 2003. Staff from the EHDI Program continues to work with programmers from Welligent to refine the data matching process. Primary care physicians were sent a packet which included information about the tracking system, guidelines for screening, diagnosis and identification for hearing loss for infants, and recommendations for appropriate referrals to pediatric diagnostic audiology centers. (IB)
Pediatric Diagnostic Audiology Centers: Audiologists in underserved areas of the state were offered the opportunity to apply for funds for equipment and education for testing of infants and young children. One private practice received funding in Fall 2003. This practice serves families living in two of the largest cities in NH and has decreased the need to travel for services for families in this area. Program staff conducted site visits to the diagnostic centers. The audiologists started entering diagnostic testing data through the Auris tracking system in March 2004. An updated list of pediatric audiology diagnostic centers was shared with physicians and hospital screening program staff. (E)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the number of hospitals in New Hampshire with newborn hearing screening programs.			X	
2. Continue the activities of the UNHSP Advisory Committee.				X
3. Monitor and analyze all newborn hearing screening data entered by participating birth hospitals into the Auris tracking system funded by the CDC Early Hearing Detection and Intervention Program.				X
4. Promote the development of pediatric audiology diagnostic centers throughout New Hampshire.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Screening Programs: The EHDI Program coordinator has discussed starting newborn hearing screening with the nurse manager of the remaining hospital without a program. (PB)

Advisory Committee: The Advisory Committee activities focused on educating parents and providers about the Auris tracking system. (IB)
Tracking System: The Auris tracking system is being used by all hospitals with newborn hearing screening programs and all audiologists testing infants. The linkage between EHDI and birth data was lost in July 2004 when the Vital Records program moved from the Department of Health and Human Services to the Secretary of State's office. (IB)
Pediatric Audiology Diagnostic Centers: Program staff have regular meetings and trainings to support audiologists who test infants in diagnostic centers as a group and continue to make site visits to work with audiologists on an individual basis. (E)
Resource Book: Parents are reviewing and sharing feedback on the Resource Book for Parents of Children who are Deaf or Hard of Hearing prior to printing. A distribution plan will be developed to assure that the materials reach families in a timely manner. (IB)

c. Plan for the Coming Year

Screening Programs: The number of hospitals with newborn hearing screening programs continues to be 23 of the 24 hospitals with birth facilities. The nurse manager of the one hospital without newborn hearing screening expects to purchase the equipment needed in the summer of 2005. (PB)
Advisory Committee: At the September 2004 meeting, members of the Advisory Committee developed the following goals: ensure the quality of hospital programs, enhance the linkages with follow-up services, develop strategies to meet the requirement for timely identification (including resources for testing infants who do not sleep for a "sleep-deprived" ABR) and develop resources to provide loaner hearing aids and assist families who cannot pay for hearing aids. (IB)
Tracking System: Staff at all hospitals with newborn hearing screening programs and all audiologists testing infants will continue entering results into the Auris tracking system. The audiologists plan to include hearing screening results for all children under the age of seven identified with hearing loss. When the linkage between EHDI and birth data is re-established, the information technology staff will expand the data transfer to include all hospitals with birth facilities. (IB)
Pediatric Audiology Diagnostic Centers: The EHDI Program staff will continue to support the audiologists through meetings and trainings and individual site visits. The audiologists will also be encouraged to attend regional programs. (E)
Resource Book: The EHDI Program staff expects to print and distribute the Resource Books. Audiologists at the Pediatric Audiology Diagnostic Centers will give them to families of infants and young children who are identified as deaf or hard of hearing. (IB)

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.5	7	6.5	6.5	6.5
Annual Indicator	8.1	5.1	5.1	5.1	5.1
Numerator	25000	15891	15891	15891	15891

Denominator	309562	309496	309496	309496	309496
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.5	6.5	6.5	6.5	6.5

Notes - 2002

The numerator is from the Insurance Family Survey, Office of Planning and Research, DHHS, NH, 2001. The denominator is from population-based estimates based on the 2000 census data.

Notes - 2003

The numerator is from the Insurance Family Survey, Office of Planning and Research, DHHS, NH, 2001. The denominator is from population-based estimates based on the 2000 census data. Data cited by the latest Current Population Survey of the Census Bureau (2001), as provided by Tricia Brooks of the NH Healthy Kids Program, is 4.8% for all children (and 2% for children under 200% FPL).

Notes - 2004

The numerator is from the Insurance Family Survey, Office of Planning and Research, DHHS, NH, 2001. The denominator is from population-based estimates based on the 2000 census data. Data used by NH Healthy Kids Corporation for this measure uses a two year average to arrive at 5.2%.

Although future objectives are set higher than current results, this is done consciously due to serious budget constraints in NH that could affect future results.

a. Last Year's Accomplishments

The MCH continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. (IB)
MCH reviewed agencies' FY'03 completed workplans in fall'03, which reported on the success or failure in the agency's ability to reach its target. Written feedback to the agencies was provided. In spring '04, MCH staff reviewed and providing feedback on the FY'05 workplans that included the same performance measures. (IB)
The MCH Child Health Nurse Consultant continued to participate in the state committee that monitors the workplans of the Robert Wood Johnson-funded "Covering Kids and Families" grant. (IB)
The MCH continued to require its contract agencies to annually assess and document the financial status of each child upon enrollment and document attempts to enroll the child on Medicaid/Healthy Kids Gold. This documentation is assessed by the MCH Contracts Administrator at agency site visits. (IB)
The MCH continued to support, with Title V and State funds, 4 community health agencies to provide "Child and Family Health Support services" in lieu of child health direct care services to support efforts made by the local agencies to enroll eligible children in Medicaid/Healthy Kids Gold and Silver. (IB)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			

	DHC	ES	PBS	IB
1. Collaborate with NH Healthy Kids and the NH SCHIP coordinator.				X
2. Participate in QCHIP and Covering Kids committee activities to improve agency efforts to enroll eligible children on Healthy Kids Gold/Medicaid.				X
3. Monitor documentation of clients' financial status and efforts to enroll on Medicaid at site visits.				X
4. Monitor agencies with expanded child health scope of service in getting eligible children enrolled on Healthy Kids Gold/Medicaid.				X
5. Monitor performance measure on contract agencies' workplans on percent of eligible children enrolled on Healthy Kids Gold/Medicaid.				X
6. Monitor agency data on uninsured children.				X
7.				
8.				
9.				
10.				

b. Current Activities

Staff from the NH Healthy Kids Program will be attending the June '05 quarterly meeting of Title V MCH contract agency Executive Directors to discuss why the number of completed applications to the state health insurance program has declined. (IB)
The MCH will request that Title V MCH Contract agencies submit their completed FY'04 workplans in fall '04 reporting on the success or failure in the agency's ability to reach its target of percent of children without health insurance. (IB)
MCH reviewed agencies' FY'04 completed workplans in fall'04, which reported on the success or failure in the agency's ability to reach its target. Written feedback to the agencies was provided. (IB)
For the FY'06 set of performance measures which contract agencies use to develop workplans, a workgroup met, with input from the contract agencies, and removed the measure pertaining to percent of uninsured children, as it was confusing in its interpretation, and clarified the definition of the measure pertaining to percent of eligible children that were enrolled in Medicaid/Health Kids Gold. (IB)
The Exhibit "A" Scope of Services for the categorically funded Child Health agencies was altered for the upcoming FY'06/07 period to allow expanded use of services that include more flexibility in using the funds for health care support services including more extensive outreach to get uninsured children enrolled on Medicaid/Healthy Kids Gold. (IB)

c. Plan for the Coming Year

Depending on the results of the June '05 Title V MCH contract agencies Directors' Meeting, staff from the NH Healthy Kids Program may be attending the fall '05 meeting of Title V MCH contract agency Program Coordinators to discuss in further detail why the number of completed applications to the state health insurance program has declined. (IB)
Meetings will be held with the four Title V funded MCH contract agencies with categorical Child Health contracts using the expanded Exhibit A. to monitor the new services and their documentation. (IB)
The MCH staff will continue to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold. (IB)
The MCH Child Health Nurse Consultant will continue to participate in the QCHIP (the quality assurance activities pertaining to the state's Child Health Insurance Program), including

providing input on recently released reports and attending meetings. (IB)
The MCH Child Health Nurse Consultant will continue to participate in the state committee that monitors the workplans of the Robert Wood Johnson-funded "Covering Kids and Families" grant. (IB)
Agencies will be adhering to the altered performance measure pertaining to getting eligible children enrolled on Healthy Kids Gold/Medicaid during FY06. The results of the workplan and performance measure will be due to MCH for review in fall '06. (IB)

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85.5	65	65
Annual Indicator	69.6	64.4	69.7	72.3	72.3
Numerator	57815	50272	63342	68982	
Denominator	83063	78005	90861	95347	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

The numerator was provided by EDS (Jim Smith) via an ad hoc report. Data for the denominator is a combination of two numbers. It includes the number of 1-21 year olds enrolled/eligible for Medicaid (from EDS). Added to this is the figure of 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. This latter number reflects uninsured 0-18 year-olds that were eligible for Health Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2003

The numerator was provided by EDS (Jim Smith) via an ad hoc report. Data for the denominator is a combination of two numbers. It includes the number of 1-21 year olds enrolled/eligible for Medicaid (from EDS). Added to this is the figure of 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. This latter number reflects uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the age groups added for the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2004

Actual data not available at this time, due to incomplete reporting from Medicaid. Therefore 2004 is an estimate based solely on 2003. 2004 data should be available in time for the 2005

autumn update.

Future objectves are consciously set below current results, due to serious budget constraints and possible future Medicaid reform.

a. Last Year's Accomplishments

The MCH staff continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates, and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold and use of Medicaid services. (IB)
MCH staff continued to worked with Title V agency staff to educate them on proper use and documentation of the Medicaid billable services at meetings with the Title V MCH agencies Directors and Program Coordinators, and at site visits. (IB)
The MCH staff conducted site visits to the 4 Title V funded non-direct care child health agencies to observe use and documentation of the MCH grant during the spring and summer of ‘04 . Lessons learned from the visits were shared with the 4 agencies at a February '04 meeting. (IB)
The MCH funded technical assistance, "CompCare", provided by Health Systems Research, Inc., released its draft report in January '04, which included services needed and used by the Title V eligible MCH population. A preliminary review and discussion of the report findings has been held. (IB)
MCH staff worked with Medicaid staff to determine national Medicaid codes that could be assigned to the local (NH developed) MCH/Medicaid billable services in accordance with national Medicaid requirements for use of only national codes. Information on use of the new codes was shared with the Title V- MCH contract agencies via meetings and mailings. (IB)
The MCH contract agencies funded for the Home Visiting New Hampshire Program continued to utilize Medicaid reimbursable services to support their activities. (IB)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator.				X
2. Participate in QCHIP and Covering Kids committee activities to improve agency efforts to enroll eligible children on Healthy Kids Gold/Medicaid and utilize Healthy Kids services.				X
3. Monitor contract agencies' use of Medicaid billable support services and work with agency staff to maximize use in an appropriately documented manner, especially the four agencies with expanded child health contract scope of services.				X
4. Monitor client’s financial documentation and efforts to enroll on Medicaid at site visits.				X
5. Monitor activities of refined performance measures on contract agencies’ workplans re: providing Medicaid-reimbursable education, support, and referral services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH staff continued to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates, and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold and use of Medicaid services. (IB)
The MCH staff will continue to monitor its contract agencies' use of Medicaid billable support services and work with agency staff to maximize use in an appropriately documented manner. (IB)
For the FY'06 set of performance measures which contract agencies use to develop workplans, a workgroup met, with input from the contract agencies, and clarified measures pertaining to the definition of the measure pertaining to percent of eligible children that were enrolled in Medicaid/Health Kids Gold, and providing education, support, and referral services, which are Medicaid-reimbursable. (IB)
The Exhibit "A" Scope of Services for the categorically funded Child Health agencies was altered for the upcoming FY'06/07 period to allow expanded use of services that include more flexibility in using the funds for health care support services including more extensive outreach to get uninsured children enrolled on Medicaid/Healthy Kids Gold. (IB)
The MCH contract agencies funded for the Home Visiting New Hampshire Program continued to utilize Medicaid reimbursable services to support their activities. (IB)

c. Plan for the Coming Year

The MCH staff will continue to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, data, updates, and policy changes to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold and use of Medicaid services. (IB)
The MCH staff will continue to monitor its contract agencies' use of Medicaid billable support services and work with agency staff to maximize use in an appropriately documented manner, especially the four agencies with expanded scope of Child Health services. (IB)
The MCH Child Health Nurse Consultant will continue to participate in the QCHIP (the quality assurance activities pertaining to the state's Child Health Insurance Program), including providing input on recently released reports and attending meetings. (IB)
Agencies will be adhering to the altered performance measure pertaining to enrolling eligible children enrolled on Healthy Kids Gold/Medicaid during FY06. The results of the workplan and performance measure will be due to MCH for review in fall '06. (IB)
The new MCH Adolescent Health Program Coordinator will be assessing how to assist Title V MCH Contract agencies to increase adolescents' use of services paid by Medicaid. (IB)
The MCH contract agencies funded for the Home Visiting New Hampshire Program will continue to utilize Medicaid reimbursable services to support their activities. (IB)

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0.8	0.8	1.5	1.5	1.5
Annual Indicator	1.3	1.1	1.1	1.1	

Numerator	195	160	158	164	
Denominator	14590	14647	14427	14383	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.1	1.1	1.1	1.1	1.1

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

Notes - 2003

2003 vital records data is not available. It will be available for the 2006 application.

Notes - 2004

CY04 data will be available next year.

Future objectives have been re-established due to three years of data which exceeds betters them. However, the objective for 2004 could not be modified.

a. Last Year's Accomplishments

The New Hampshire Chapter of the March of Dimes along with the Northern New England Perinatal Quality Improvement Network cosponsored a Summit on Prematurity. The DHHS provided leadership in presenting the public health perspective and launching a call to action at the Summit closing. (E, I)

MCH-funded agencies continued to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services has been revised to reflect the program's focus on smoking during pregnancy and first trimester entry to care.

The MCH has led the New Hampshire 2010 MCH Committee during this reporting period. The committee has chosen the reduction of low birth weights as one of the priority objectives under the initiative. Actions steps and strategies have been developed. The action steps will be implemented in FY05 and FY06. The focus of the Committee objectives include increased smoking cessation interventions among providers, implementation of clinical protocols for alcohol and other drug screening and interventions, and increased communication between Dartmouth Hitchcock Medical Center (New Hampshire's largest referral facility) and Community Health Centers working with the highest risk populations for poor birth outcomes. (E, P)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to facilitate the MCH 2010 sub-committee of the New Hampshire 2010 Initiative. Objectives of the MCH 2010 Committee include promotion of provider cessation intervention with pregnant			**X**	**X**

patients, alcohol screening in prenatal care settings, an				
2. Continue to facilitate the Birth Outcomes Workgroup to develop and implement initiatives to reduce lowbirth weights in New Hampshire.		X	X	X
3. Convene community partners to reduce disparities in prenatal adequacy rates and poor birth outcomes based on indentified socio-demographic charictaristics.			X	
4. Continue to disseminate best practice interventions and updated guidelines among prental care providers within the publically funded health center network.			X	X
5. Submit a PRAMS application to survey a representative sampling of New Hampshire women on health issues, status and experiences in pregnancy.				X
6. Continue to facilitate Prenatal Nurse Coordinator meetings.				X
7. Continue to meet with the Performance Management Team to coordinate provider site reviews.			X	X
8.				
9.				
10.				

b. Current Activities

The Bureau of Maternal and Child Health will continue to foster a collaborative relationship with the Perinatal Program at Dartmouth Hitchcock Medical Center.
MCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were evaluated using preliminary agency trend data from the years SFY 2002 through 2005. In addition, the Prenatal Performance Measures were reviewed and updated to reflect the program's focus on prenatal smoking and first trimester entry to care. (D)

The MCH will release reports on New Hampshire births and disparities in birth outcomes through the Title V needs assessment process. The prenatal report will present findings on prenatal access to care as well as birth outcomes with particular focus on the analysis of stratified data on socio-demographic characteristics. A second report will present disparities in birth outcomes within the minority populations of New Hampshire. These reports will be used to inform general planning efforts with contract agencies of MCHS and in particular the Birth Outcomes Workgroup. (I)(E)

c. Plan for the Coming Year

A series of meetings with the prenatal clinical coordinators of the MCHS funded agencies and the Children's Hospital at Dartmouth will continue throughout the year. The meetings are designed as working meetings to revise and augment existing clinical protocols for prenatal care based on the most recent evidence based protocols available. Each agency will participate in the review and feedback on protocols as well as dialogues on the clinical implementation of key recommendations with the completed protocols. The dialogue will facilitate closer clinical coordination between providers and the referral facility for high-risk deliveries. The protocols will ensure that both providers and Dartmouth Neonatology have established clear expectations in clinical care and referral protocols. (I)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	138.3	138	138	138
Annual Indicator	10.4	138.3	122	122	
Numerator	9				
Denominator	86688				
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	138	138	138	138	138

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

The 2001 indicator for this measure was calculated using the Standardized Ratio methodology, as described in the block grant guidance. Raw data is as follows:

numerator - 10 "events"
denominator - 88230
U.S. rate - 8.2

Source for U.S. data: www.cdc.gov/nchs/fastats/pdf/nvsr50_16tl.pdf

Notes - 2003

Most recent death data available from Vital Records is calendar year 2002. This 2002 data is used as an estimate for 2003, as 2003 data will not be available until the 2006 application.

The 2002 indicator for this measure was calculated using the Standardized Ratio methodology, as described in the block grant guidance. Raw data is as follows:

numerator - 9 "events"
denominator - 89772
U.S. rate - 8.2

Source for U.S. data: www.cdc.gov/nchs/fastats/pdf/nvsr50_16tl.pdf

Future objectives have purpsosely been set above current results due to very small numbers and budget constraints.

Notes - 2004

Latest data available is 2002. See note for 2003.

a. Last Year's Accomplishments

Youth Suicide Prevention Assembly (YSPA): YSPA continued to meet monthly to develop the Statewide Suicide Prevention State Plan as well as the state's first Annual Report on Youth Suicide. The plan and report were released in November of 2004 at a special conference initiated by the Commissioner of Health and Human Services. YSPA established a speakers' bureau, which has facilitated several talks in different venues, including radio and television. YSPA members also helped organize an expanded Survivors Conference in conjunction with the American Foundation for Suicide Prevention teleconference. (I & P)
Policy: The New Hampshire Legislative House Study Committee made recommendations to recognize YSPA, encourage development of a state plan and increase access to training on suicide prevention for school personnel. YSPA members testified and assisted with the development of recommendations. (I)
Frameworks Project: Work groups completed the intervention protocols, preparing to begin work on postvention. Pilot site recruitment took place with the selection of a place occurring. (P)
Counseling on Restricting Access to Lethal Means: Funds were received for the initiation of this project. (I)
Medical Examiner Case Review: The second round of reviews of Medical Examiner records on youth suicides, including an analysis was completed. (P)
Training: A group participated in Harvard's Injury Prevention Research Center's suicide prevention training. (I)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Represent Public Health Services on (YSPA).				X
2. Implement the Statewide Suicide Prevention Plan.			X	X
3. Continue to serve on the Frameworks Steering Committee, Advisory Board, and workgroups.				X
4. Secure funding for ongoing planning and implementation of suicide prevention training and education activities.				X
5. Facilitate annual survivor’s conference.			X	
6. Convene and chair the Firearm Safety Coalition.			X	X
7. Develop firearm safety video for high school age adolescents.			X	
8. Gather and publish data from the adolescent psychological autopsy project.			X	
9.				
10.				

b. Current Activities

YSPA and Statewide Suicide Prevention Plan: Regular meetings are continuing. Efforts are being made to secure funding to allow for ongoing planning and completion of suicide prevention training and education activities. Implementation of the Statewide Suicide Prevention Plan is ongoing. (I & P)
Frameworks Project: The Frameworks Project is working on its postvention protocols, with implementation at its community pilot site, the Mascoma Valley Health Initiative, just getting underway. (P)
Training: A group is participating in the Suicide Prevention Resource Center's training this spring in addition to a Northeast Injury Prevention Network training on poison prevention. (P)
Counseling on Restricting Access to Lethal Means: This project is getting underway with

additional help from the Harvard Injury Prevention Research Center who will be doing the evaluation component. (I & P)
Medical Examiner Case Review: Reviews of the Medical Examiner record on youth suicides is continuing on an ongoing basis. The data collected is being utilized for planning and intervention purposes. (I)
Psychological Autopsies: Funding was received and encumbered to allow for in depth psychological autopsies to be completed on a subset of the Medical Examiner's adolescent suicide cases. (I)
Maternal and Child Health Infrastructure: An adolescent health coordinator was hired who will devote one quarter of her time to suicide prevention. In addition, a poison educator dedicated to New Hampshire, recently started work and sits within the Section, although working for the state's poison center contractor, the Northern New England Poison Center. (I)

c. Plan for the Coming Year

YSPA and the Statewide Suicide Prevention Plan: Meetings of YSPA will continue to be held monthly. A group, formed of those organizations implementing the Statewide Suicide Prevention Plan, will continue to meet to monitor the implementation and its progress. (I & P)
Frameworks: The Mascoma Valley Health Initiative will implement the Frameworks guidelines with help from the Steering Committee and Advisory Board. (P)
Psychological autopsies: These will be initiated and completed with analysis being done and findings published. (I & P)
Counseling on Restricting Access to Lethal Means: This project will be completed. (I & P)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	86	86	86	86
Annual Indicator	88.1	88.5	84.1	80.0	
Numerator	119	100	116	96	
Denominator	135	113	138	120	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application

period.

Denominator is occurrent very low birth weight births. Level III facility information is not available for out-of-state births. Because this data is occurrences, the denominator does not match the numerator for performance measure # 15, i.e. PM # 15 data is resident births.

Notes - 2003

2003 vital records data is not available. It will be available for the 2006 application.

Data is for occurrent births. Level III facility information is not available for out-of-state births. Because this data is occurrences, the denominator does not match the numerator for performance measure #15, i.e. PM #15 data is resident births.

Notes - 2004

CY04 data will be available next year.

a. Last Year's Accomplishments

The New Hampshire Chapter of the March of Dimes along with the Northern New England Perinatal Quality Improvement Network cosponsored a Summit on Prematurity. The DHHS provided leadership by presenting the public health perspective and launching a call to action at the Summit closing. (E, I)
MCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. Performance measures for local prenatal clinics were evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. In addition, the Prenatal Scope of Services has been revised to reflect the program's focus on prenatal smoking and first trimester care entry. A performance management system for all agencies is in the design phase with implementation expected by the Fall of FY05 (D)
The MCH has led the New Hampshire 2010 MCH Committee during this reporting period. The committee has chosen the reduction of low birth weight as one of the priority objectives under the initiative. Actions steps and strategies have been developed. The action steps will be implemented in FY05 and FY06. Education at statewide provider transfer conferences will be used to implement education strategies. (E, P)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to facilitate the MCH 2010 sub-committee of the New Hampshire 2010 Initiative. Objectives of the MCH 2010 Committee include promotion of provider cessation intervention with pregnant patients, alcohol screening in prenatal care settings, an			X	X
2. Continue to facilitate the Birth Outcomes Workgroup to develop and implement initiatives to reduce lowbirth weights in New Hampshire.		X	X	X
3. Convene community partners to reduce disparities in prenatal adequacy rates and poor birth outcomes based on identified socio-demographic characteristics.			X	
4. Continue to disseminate best practice interventions and updated guidelines among prenatal care providers within the publicly funded health center network.		X	X	
5. Submit a PRAMS application to survey a representative sampling of New Hampshire women on health issues, status and experiences in pregnancy.				X

6. Continue to facilitate Prenatal Nurse Coordinator meetings.				X
7. Continue to meet with the Performance Management Team to coordinate provider site reviews.			X	X
8.				
9.				
10.				

b. Current Activities

MCH will continue to foster a collaborative relationship with the Perinatal Program at Dartmouth Hitchcock Medical Center.
MCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women.

Performance measures for local prenatal clinics were instituted during the SFY 2002 cycle. During FY 2003, these were evaluated using preliminary agency data and revised for the SFY 2004 competitive bidding cycle. Performance trend data has been developed for the years 2002 -- 2005 and reported back to agencies to use in the development of 2006 workplan strategies and action steps. (I)

c. Plan for the Coming Year

A series of meetings with the prenatal clinical coordinators of the MCH funded agencies and the Children's Hospital at Dartmouth will continue throughout the year. The meetings are designed as working meetings to revise and augment existing clinical protocols for prenatal care based on the most recent evidence based protocols available. Each agency will participate in the review and feedback on protocols as well as dialogues on the clinical implementation of key recommendations with the completed protocols. The dialogue will facilitate closer clinical coordination between providers and the referral facility for high-risk deliveries. The protocols will ensure that both prenatal care providers and the Children's Hospital at Dartmouth - Neonatology have well-recognized expectations in clinical care and referral protocols. (I)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	88	88	88
Annual Indicator	87.8	88.2	89.5	91.0	
Numerator	12803	12923	12911	13090	
Denominator	14590	14647	14427	14383	
Is the Data Provisional or				Final	

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

Notes - 2003

2003 vital records data is not available. It will be available for the 2006 application.

Notes - 2004

CY04 data will be available next year.

Future objectives are set lower than 2003, since data from other years is worse than 2003 - and because 2004 data is not available.

a. Last Year's Accomplishments

MCH-funded agencies continued to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)
MCH-funded Prenatal Program Coordinators' meetings were held on a biannual basis. These meetings provided a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered included oral health, Medicaid compliance in billing practices for support services, prenatal clinical guidelines development, and the development of performance workplans. (I, E)
Minority focus group information and a birth data report were completed in FY 03. This information was utilized to inform further data requests related to early and adequate prenatal care. (I)
A Performance Management Collaborative was formed to create a comprehensive system of performance management across state and community systems. The collaborative is made up of MCH staff and provider agency directors. The collaborative has developed a web-based report card for Health Center Programs funded by the Maternal and Child Health Section. (E, I)

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to facilitate the MCH 2010 sub-committee of the New Hampshire 2010 Initiative. Objectives of the MCH 2010 Committee include promotion of provider cessation intervention with pregnant patients, alcohol screening in prenatal care settings, an			**X**	**X**
2. Continue to facilitate the Birth Outcomes Workgroup to develop and implement initiatives to reduce lowbirth weights in New Hampshire.		**X**	**X**	**X**
3. Convene community partners to reduce disparities in prenatal adequacy rates and poor birth outcomes based on identified socio-demographic characteristics.			**X**	
4. Continue to disseminate best practice interventions and updated guidelines among prenatal care providers within the publicly funded health center network.		**X**		**X**

5. Submit a PRAMS application to survey a representative sampling of New Hampshire women on health issues, status and experiences in pregnancy.				**X**
6. Continue to facilitate Prenatal Nurse Coordinator meetings.				**X**
7. Continue to meet with the Performance Management Team to coordinate provider site reviews.			**X**	**X**
8.				
9.				
10.				

b. Current Activities

MCH-funded agencies continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)
MCH-funded Prenatal Program Coordinators' meetings continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics to be covered at the FY 2005 meetings include: The 5A's model of prenatal smoking cessation; prematurity data and best practices; and performance management. (E)
The Prenatal Program continues to explore options for implementing a PRAMS-like survey. The program's 2001 CDC application for PRAMS was approved but not funded. The program will submit a PRAMS application in the 2005 competitive bid cycle. (P, I)
MCH continues to collaborate with the NH March of Dimes on a statewide campaign to increase awareness of the health impact of preterm births and to promote early prenatal care. (P)
The MCH began reporting on performance measures - both health status and infrastructure through the web-based report card. (I)
Stakeholders within the Division of Public Health Services as well as community providers were brought together at an initial meeting of the Birth Outcomes Workgroup. The mission of the Workgroup is to identify strategic action steps that will lead to improved birth outcomes through targeted evidence based interventions. A particular emphasis will be on the recruitment and retention of prenatal patients in order to address adequacy of prenatal care and birth outcomes. Workgroup membership includes representation from; Division of Alcohol, Drug, and Tobacco Prevention, Women, Infants, and Children's Program, Medicaid Policy, community providers, the Minority Health Coalition, and Dartmouth Hitchcock Medical Center. (I)

c. Plan for the Coming Year

MCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)
MCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics to be covered at the FY 2006 meetings include recruitment and retention of prenatal patients.

A data analysis will be completed for trend data on adequacy of prenatal care stratified by residence, age, ethnicity, smoking status, and payer source. Based on this analysis, the Birth Outcomes Workgroup will identify, design, and implement a model strategy in Manchester and Nashua to increase early entry to prenatal care for target populations. This analysis will be informed by a series of key informant interviews with health care providers, community health advocates, birthing facilities staff, and public health workers in Manchester and Nashua. A final report will be written and presented to the Birth Outcomes Workgroup and subsequently to key stakeholders in Manchester and Nashua. (P, I)

The Birth Outcomes Workgroup will recommend strategic action steps or a single model program to address disparities in prenatal access and adequacy of care in the Manchester area. Recommendations will be specifically tailored to address disparities identified by the data analysis report described above. (P, E, I)

We anticipate conducting a PRAMS in New Hampshire upon receipt of a grant award under the 2005 funding cycle. (P, I)

D. STATE PERFORMANCE MEASURES

State Performance Measure 2: *Percent of women statewide who smoked during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	12	16	16	16
Annual Indicator	16.6	15.5	15.0	14.1	
Numerator	2382	2222	2116	2032	
Denominator	14327	14342	14116	14383	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16	16	16	16	16

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

Notes - 2003

2003 vital records data is not available. It will be available for the 2006 application.

Notes - 2004

2004 data not available until next year

a. Last Year's Accomplishments

A meeting facilitated by staff and attended by all MCH contracted Prenatal providers focused disucussions of best practice in prenatal smoking cessation. The agencies attending committed to the implementation of the Five A's program as the standard for cessation intervention with prenatal patients. Participants that had received a "train the trainers" education program, committed to training other New Hampshire based and interested prenatal care providers in the 5A's intervention and clinical implementation in practice. (E, I)

The New Hampshire Perinatal 2010 Committee has chosen an objective targeting a reduction of smoking in pregnant women. A minimum of two action steps under this objective will be implemented in the coming year. (P, I)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to facilitate the MCH 2010 sub-committee of the New Hampshire 2010 Initiative. Objectives of the MCH 2010 Committee include promotion of provider cessation intervention with pregnant patients, alcohol screening in prenatal care settings, an				X
2. Continue to facilitate the Birth Outcomes Workgroup to develop and implement initiatives to reduce low birth weights in New Hampshire.				X
3. Convene community partners to reduce disparities in prenatal adequacy rates and poor birth outcomes based on identified socio-demographic characteristics.				X
4. Continue to disseminate best practice interventions and updated guidelines among prenatal care providers within the publicly funded health center network.		X		X
5. Submit a PRAMS application to survey a representative sampling of New Hampshire women on health issues, status and experiences in pregnancy.				X
6. Continue to facilitate Prenatal Nurse Coordinator meetings.			X	X
7. Continue to meet with the Performance Management Team to coordinate provider site reviews.				X
8.				
9.				
10.				

b. Current Activities

All MCHS contracted providers will use the Five A's model to assist pregnant women to quit smoking. (D)(E)(I)

The Prenatal Program will continue to explore options for the funding of a PRAMS-like survey. (P)(I)

c. Plan for the Coming Year

MCH has made smoking cessation clinical intervention throughout pregnancy a performance measure under all prenatal contracts. This measure is reported back to the agencies as trend data. The agencies submit workplans on the strategies, action plans, evalaution, and outcomes. The tobacco intervention is a primary focus between the MCH and our contracted providers. (P, I)

The New Hampshire Home Visiting Program established performance measures on tobacco cessation intervention for home visiting agencies. The agencies will monitor and report on these performance measures. (P, I)

The MCH in collaboration with Dartmouth Hitchcock Childrens Program will disseminate the Five A's model to all Hospitals and birthing centers throughout the state. This dissemination and brief training in the model will occur through grand rounds type presentations between September 2005 and June 2006. These transport conferences are already established. (E) (P)

State Performance Measure 8: *Percent of state contracted, non Head Start or Head Start affiliated child care programs that receive a minimum of one hour per month on-site consultation from a qualified child care health consultant*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	40	45	12.9	13	9
Annual Indicator	35.6	35.0	12.9	9.4	5.0
Numerator	16	14	4	3	2
Denominator	45	40	31	32	40
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	9	

Notes - 2002

The definition of this measure has been refined, and the qualifications for achievement have been significantly tightened. This results in what appears like a decrease in performance in 2002. In actuality, the changes now allow us to measure results in a much more precise and meaningful way. Objectives have been adjusted accordingly.

A qualified child care health consultant, as recognized by the Healthy Child Care New Hampshire Project, is a licensed RN, NP, PA, or MD with pediatric or family health training. Undergraduate nursing students shall be acceptable as child care health consultants if supervised by faculty knowledgeable in child care.

Head Start and Head Start affiliated child care programs are exempt from the measurement data, as these programs receive health consultation services from Head Start health managers.

Notes - 2003

A qualified child care health consultant, as recognized by the Healthy Child Care New Hampshire Project, is a licensed RN, NP, PA, or MD with pediatric or family health training. Undergraduate nursing students shall be acceptable as child care health consultants if supervised by faculty knowledgeable in child care.

Head Start and Head Start affiliated child care programs are exempt from the measurement

data, as these programs receive health consultation services from Head Start health managers.

Notes - 2004

This measure is being discontinued.

a. Last Year's Accomplishments

Child Care Health Consultation Network

HCCNH contributed to the development and implementation of the New England Child Care Health (HCCNE) Consultant Community of Practice website, http://hccne.communityzero.com/hccne. (IB)

Seven CCHC completed the HCCNE four-day Child Care Health Consultation (CCHC) training series.

HCCNH and Healthy Child Care Vermont co-sponsored a CCHC networking meeting and Adult Training Techniques workshop. (IB)

HCCNH co-sponsored a CCHC networking workshop with DHHS Immunization Program, piloting an Immunization training module from the companion trainers guide to the Health and Safety Manual for New Hampshire Child Care Providers. (IB)

Child Care Provider Education and Training

HCCNH co-sponsored a CCHC networking workshop with DHHS Immunization Program, piloting an Immunization training module from the companion trainers guide to the Health and Safety Manual for New Hampshire Child Care Providers. (IB)

HCCNH supplied 50 requests from child care providers for the Health and Safety Manual for New Hampshire Child Care Providers. (PB)

HCCNH continued to give presentations to child care providers and early childhood education students through the Child Development Bureau's Infant Toddler Series, the NH Child Care Resource and Referral (NHCCR&R) network (D).

Partnership Development

HCCNH successfully transitioned from a program coordinated outside the state system by a consulting agency into a program embedded within the state Bureau of Maternal and Child Health and the program officially became aligned with other Early Childhood Comprehensive Systems (ECCS) activities and plans. This process formalized the relationship of the program with other child health activities, including ECCS. (IB) Partnership with DHHS immunization program led to an initiative to revise the annual child care immunization survey. (IB)

HCCNH initiated the first of bi-annual meetings of DHHS programs concerning lead, asthma, children with special health care needs, immunization, injury prevention, oral health and obesity with the NHCCR&R network representative and ELNH representative. This group will focus on streamlining and maximizing program efforts related to child care.(IB)

Collaboration with the State Fire Marshall's office resulted in implementing an injury prevention curriculum, Risk Watch(r), into child care settings through the NHCCRR. (IB)

HCCNH Project Coordinator continued monthly board attendance on Governor's Child Care Advisory Council with a new appointment to Early Learning NH Advisory (ELNH) Board and the Manchester Child Care Advisory Council. (IF)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided 4 day HCCNE CCHC training for seven NH health professionals.			X	

2. Hosted one day medication administration seminar for key NH administrators in collaboration with HCCNE.				X
3. Facilitated bi-annual meetings with DHHS health programs and NH Child Care Resource and Referral network and Early Learning New Hampshire.				X
4. Collaborated with Maternal and Child Health Section in securing $ 50,000 to fund CCHC direct service activities.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Child Care Health Consultant Network
In June through August, Healthy Child Care New Hampshire (HCCNH), in collaboration with the other New England states (HCCNE) provided 4 days of training for CCHCs (IB). Seven CCHC from NH completed the training. These consultants provided limited volunteer consultation to child care providers(D).
In May, the New Hampshire Maternal and Child Health Section secured funding of $50,000 for paying CCHC for direct consultation service (IB)

Child Care Provider Education and Training
HCCNH provided ongoing technical assistance by phone, on site, electronically, and through the provision of written and audio resources to CCHC, child care providers and other health professionals. (D)
HCCNH facilitated presentations concerning injury prevention, asthma, infectious disease and immunization to early childhood educators through the ELNH annual conference in October. (D)
The Health and Safety Manual for New Hampshire Child Care Providers and the Disease Handbook for Child Care Providers continued to be provided free of charge at state wide conferences and through local the NHCCR&R network.(PB)

Partnership Development
HCCNH project coordinator continued to provide a minimum of monthly consultation to the Governor's Child Care Advisory Committee; ELNH board meetings, ELNH Fund Development committee and ELNH Annual Conference committee. (IB).
HCCNH in partnership with HCCNE sponsored a one day seminar on medication administration that brought together administrators from the Board of Nursing, Child Care Licensing, Child Development Bureau, NHCCR&R network and ELNH (IB)

HCCNH facilitated two meetings with NHCCR&R, ELNH, and DHHS departments with initiatives concerning lead, asthma, children with special health care needs, immunization, injury prevention, oral health and obesity. This group provided workshop presentations to the ELNH annual conference and informational resources to the first annual NHCCR&R conference.(IB).

c. Plan for the Coming Year

This measure has been discontinued.

State Performance Measure 9: *Percent of high school students who smoked cigarettes during the past 30 days*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30	30	30	27	27
Annual Indicator	34.1	25.3	25.3	25.3	19.1
Numerator	611				
Denominator	1793				
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	20	20

Notes - 2002

FY2001 and FY2002 data come from the 2002 Youth Tobacco Survey (Susan Knight, NH Tobacco Program). The data is weighted and based on a random sample of NH high school students in grades 9-12. Because the data is weighted, the numerator (334) and denominator (1395) are not included on Form 11. The Youth Tobacco Survey will be done again in the fall of 2004.

Notes - 2003

FY2001, FY2002, and FY2003 data come from the 2002 Youth Tobacco Survey (Susan Knight, NH Tobacco Program). The data is weighted and based on a random sample of NH high school students in grades 9-12. Because the data is weighted, the numerator (334) and denominator (1395) are not included on Form 11. The Youth Tobacco Survey will be done again in the fall of 2004.

Notes - 2004

FY2004 comes from the 2004 Youth Tobacco Survey (Susan Knight, NH Tobacco Program). The data is weighted and based on a random sample of NH high school students in grades 9-12. Because the data is weighted, the numerator (254) and denominator (1407) are not included on Form 11. The Youth Tobacco Survey will be done again in the fall of 2006.

a. Last Year's Accomplishments

Due to the vacancy of the Adolescent Health Coordinator position, core initiatives in progress were maintained but new initiatives were restricted. Thus the priorities under this initiative were the completion of the Adolescent Strategic Planning Project and the dissemination of the plan itself. Collaborations with other programs such as the Tobacco Control Program and the Adolescent Health Resource Center at the University of New Hampshire allowed completion of tobacco control initiatives reported below.
The Adolescent Health Program completed its Strategic Planning process. A written needs assessment for adolescent health including information on adolescent smoking is a prominent section of the overall plan document. (E)(I)

The final strategic plan will be disseminated among all identified stakeholder groups including health care providers, school health representatives, and community coalitions in order to motivate broad based support for youth prevention efforts such as tobacco control initiatives. (I)
The Annual "Youth Network Opposing Tobacco" Conference was co-sponsored by the NH Tobacco Control Program. This conference brought legislators, youth, public health officials, and community leaders together for a day-long conference. Topics covered in the conference included; media (movies) effects on youth tobacco use, tobacco advertising tactics, women and tobacco use, and empowering youth through engagement in prevention initiatives. (I)(E)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Program continued to coordinate the State Youth Collaborative, a group consisting of state agencies whose programs impact youth, including representation from the Tobacco Prevention and Control Program. The group goal was to coordinate efforts to improve adolescent health. (I)
The MCH funded Teen Clinic in Manchester continues to assess for tobacco use among its clients and to offer prevention and cessation interventions. (D, I)
The Adolescent Health Program is still planning on developing a teen advisory group to engage youth in the development of state programs and services. (I)
Adolescent Health Program staff continues to participate in Youth Network Opposing Tobacco events and consult with the TPCP on youth activities. (D)(P)(I)

c. Plan for the Coming Year

MCH is being discontinued. However, the Adolescent Health Program will continue to work and consult with the Tobacco Prevention and Control Program on youth-related activities. MCH also will continue to sub-contract with the Teen Clinic in Manchester and require that tobacco use be assessed and cessation interventions be offered. We will also continue to participate in Youth Network Opposing Tobacco events and other prevention activities. (D)(P)(I)

State Performance Measure 10: *Percent of third grade children screened who had untreated dental decay.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	29	22.6	21.6	21.7	22
Annual Indicator	22.6	21.7	21.7	21.7	24.2
Numerator	1101	89	89	89	142
Denominator	4875	410	410	410	587
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24.2	24.2	24.2	24	24

Notes - 2002

Statewide oral health data for measures #9 and 10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey will be conducted for the second time in the spring of 2004 and thereafter every three years. The Oral Health Program will not know until the 2004 survey results are analyzed if we have achieved our objective. The 2001 Oral Health Survey of Third Grade Students indicated that 46% of third graders had dental sealants on at least one permanent tooth and that that 22% of third graders had untreated decay. To reach the Healthy New Hampshire 2010 goal of 60% of third graders with sealants, each year an additional 1.5% students will need to receive sealants. To approximate the national Healthy People 2010 objective and reduce the percent of students with untreated decay to 19% by 2010, an additional .4 % of students each year must show reduced levels of untreated decay. Results of the 2004 statewide survey will indicate if we are on track to achieve the 2010 goals.

Notes - 2003

Statewide oral health data for NPM #9 and SPM #10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey will be conducted for the second time in the spring of 2004 and thereafter every three years. The Oral Health Program will not know until the 2004 survey results are analyzed if we have achieved our objective. The 2001 Oral Health Survey of Third Grade Students indicated that 46% of third graders had dental sealants on at least one permanent tooth and that that 22% of third graders had untreated decay.

Notes - 2004

Statewide oral health data for NPM #9 and SPM #10 is collected every three years through The Oral Health Survey of Third Grade Children. The survey was conducted for the second time in the spring of 2004 and will be repeated every three years.

Given state budget constraints, the performance measure objectives for 2005-2009 have been adjusted.

a. Last Year's Accomplishments

In cooperation with the CDC chronic disease epidemiologist, OHP collected, analyzed, and added new data from 16 state-funded programs to the statewide surveillance system. (IB, PBS, ES)
The OHP collaborated with the CDC epidemiologist to publish New Hampshire Oral Health

Data, 2003 reporting on all 8 national oral health indicators. (IB, PBS, ES)
The CDC epidemiologist and OHP Manager presented data from the NH Oral Health Surveillance System, comparing baseline data from the 2001 NH Oral Health Survey of Third Grade Students with annual programmatic data from 17 school-based dental programs. (IB, ES, PBS)
The OHP conducted the second Oral Health Survey of Third Grade Students using the ASTDD model to screen children for the percent of third grade students with untreated decay. (IB, ES, PBS, DS).
The OHP collaborated with the Endowment for Health to participate in regular meetings of the NH Coalition for Oral Health Action a group focused on the implementation of the New Hampshire Oral Health Plan: A Framework for Action. The Implementation Subcommittee meets regularly to prioritize and implement the plan's recommendations to improve the oral health status of NH residents. (IB, ES, PBS, ES)
The OHP collaborated with the Endowment for Health to fund the implementation of the first year of the three-year NH Statewide Sealant Project that will increase the percent of third grade students with sealants and refer those with untreated decay to community dentists. (IB, PBS, ES, DS).
The OHP collaborated with the Endowment for Health to implement an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).
The OHP collaborated with NH Head Start to convene a statewide Head Start Oral Health Forum. In collaboration with New England dental directors and Region I administrators, the OHP convened a New England regional Head Start Oral Health Forum in June '04. Special Medical Services Bureau staff (McCann) participated in this Forum and the follow-up work group. She provided information about children with special health care needs and provided training resources for dentists and hygienists who offer care to this population. (IB, PBS, ES, DS).
The OHP collaborated with Area Health Education Centers (AHEC) to secure HRSA funds to collect, review, and brand oral health materials to assist NH's primary care providers with the integration of oral health into total health care delivery for their patients. (IB, PBS, ES)
The OHP collaborated with MCH partners in the Early Childhood Collaborative Systems Grant including oral health objectives. (ES, PBS, IB)
The OHP collaborated with the Medicaid Dental Director as she made contacts with dentists in public and private practices informing them about recent Medcaid rate increases and ongoing efforts to make the program more customer friendly. (IB, ES, PBS, DS)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OHP and Medicaid will continue to collaborate to find treatment for clients.		X	X	X
2. Collaborating with Medicaid and EFH, the OHP will open new dental programs in Coos and Grafton counties, Sullivan County, Carroll County and in the Rochester region.	X	X	X	X
3. The OHP will continue collaboration with EFH in year two of the NH Statewide Sealant Project applying sealants on second and third graders in three additional pilot schools and referring students with untreated decay to local dentists.	X	X	X	X
4. The OHP will collaborate with Maine and Massachusetts on the implementation of the “Watch Your Mouth” campaign, using Boston media markets to increase public perception of the value of good oral health as		X	X	X

a component of overall health.				
5. Collaborating with Community Health Access Network (CHAN) the OHP will continue working to integrate oral health assessment into medical care by educating providers, patients, and parents while implementing the aggressive use of evidence-based preven	X	X	X	X
6. Collaborating with the NH Loan Repayment Program, the OHP will recruit dentists for underserved areas of the state.		X	X	X
7. The OHP will collaborate with Southern NH Area Health Education Centers (AHEC) and the Minority Health Coalition to inventory oral health educational materials, select the best,“brand” them for the NH market, and test them with provider and consumer		X	X	X
8. The OHP will collaborate with MCH partners in the Early Childhood Collaborative Systems Grant including oral health objectives.		X	X	X
9.				
10.				

b. Current Activities

The OHP collaborates with the Medicaid Dental Director as she makes frequent contacts with dentists in public and private practices informing them about recent Medcaid rate increases and ongoing efforts to make the program more customer friendly. (IB, ES, PBS, DS)
The OHP will continue collaborating with Northeast Delta Dental to complete an applied research grant to analyze three strategies for financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).
The OHP provides ongoing technical assistance to communities initiating new oral health programs. (IB, ES, PBS)
The OHP works closely with the Statewide Sealant Task Force and EFH on the implementation of the first year of the three-year sealant project to increase the amount of protective sealants on NH's high-risk children and refer those with untreated decay to dentists in the community. (IB, PBS, ES, DS)
The OHP is participating in spokesperson trainings with representatives from Maine and Massachusetts to implement the "Watch Your Mouth" (WYM) oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)
The OHP is collaborating with Area Health Education Centers (AHEC) on year one of the State Oral Health Collaborative Systems (SOHCS) grant, "Children's Oral Healthcare Access Program" to collect, review, and brand oral health materials to assist NH's primary care providers with the integration of oral health into total health care delivery for the families of their patients 0-3 years. (IB, PBS, ES)
The OHP is collaborating with MCH partners in the Early Childhood Collaborative Systems Grant to assure the incorporation of oral health objectives into early childhood comprehensive systems. (ES, PBS, IB)
The OHP is collaborating with CDC assignee Leigh Ramsey, PhD to publish the results of the second Oral Health Survey of Third Grade Students. (IB, PBS, ES)
The OHP is collaborating with physicians, representatives from NH MCH, and the NH Department of Environmental Services to improve protocols for well water testing for fluoride content in order to improve physicians' ability to prescribe appropriate fluoride supplementation for at-risk children. (IB, PBS, ES)
In collaboration with NH Medicaid and the Endowment for Health, the OHP anticipates the opening of the first public dental center in Sullivan County, the addition of another hospital-based dental center in Manchester, and the expansion of two established urban dental centers in Manchester and Nashua. "The Molar Express," a mobile dental program is currently providing preventive treatment while it recruits a fulltime dentist to provide comprehenive oral health care for children and adults in northern Coos and Grafton counties. (IB, ES, PBS, DS)

c. Plan for the Coming Year

In collaboration with NH Medicaid and the Endowment for Health, the OHP anticipates the opening of the first public dental center in Sullivan County, the addition of another hospital-based dental center in Manchester, and the expansion of two established urban dental centers in Manchester and Nashua. "The Molar Express," a mobile dental program will recruit a fulltime dentist to provide comprehenive oral health care for children and adults in northern Coos and Grafton counties. (IB, ES, PBS, DS)

The OHP will continue working with the Dental Director and Medicaid Program to inform and educate dental professionals about programmatic improvements and increases in Medicaid reimbursements to increase the number of enrolled dental providers. (IB, ES, PBS, DS)

The OHP and Northeast Delta Dental will complete an applied research grant and report the results of the analysis of three strategies for the financing and delivery of Medicaid oral health services. (IB, PBS, ES, DS).

The OHP will continue to provide technical assistance to communities seeking to start new oral health programs (IB, ES, PBS)

In cooperation with the newly hired chronic disease epidemiologist, OHP will collect, analyze, and add new data from 16 state-funded oral health programs to the statewide surveillance system. (IB, PBS, ES)

The OHP will continue collaborating with EFH and the NH Dental Society on year two of the NH Statewide Sealant Project to develop a sustainable statewide school sealant program, increase the amount of protective sealants on NH's high-risk children, and refer those with untreated decay to community dentists for treatment. (IB, PBS, ES, DS)

The OHP will participate with representatives from Maine and Massachusetts in the development of "Watch Your Mouth" (WYM) materials and media messages for this oral health education and awareness campaign to increase public perception of the importance of good oral health as a component of overall health. (IB, ES, PBS)

The OHP will continue collaborating with Area Health Education Centers (AHEC) and the Minority Health Coalition in the second year of the State Oral Health Collaborative Systems Grant (SOHCS), "Children's Oral Healthcare Access Program." We will convene focus groups of consumers and physicians to discover the barriers to access to dental care before developing a plan to to assist NH's primary care providers with the integration of oral health into total health care delivery for families of patients 0-3. (IB, PBS, ES)

The OHP will continue collaborating with MCH partners in the Early Childhood Collaborative Systems Grant to assure the incorporation of oral health objectives into early childhood comprehensive systems. (ES, PBS, IB)

The OHP will collaborate with physicians and the Foundation for Healthy Communities to develop Oral Health Prevention Guidelines to be distributed as posters to physicians offices across the state. (IB, PBS, ES)

State Performance Measure 11: *Percent of children age two (18-29 months) on Medicaid who have been tested for lead.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		25	30	30	30

Annual Indicator		25.4	31.5	23.3	27.2
Numerator		991	1335	1252	1263
Denominator		3894	4232	5365	4646
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27	27	27	27	27

Notes - 2002

Information for this measure was provided by Chris Cullinan of the NH Childhood Lead Poisoning and Prevention Program (CLPP). It included data originating from the Medicaid Administration Bureau via the CLPP.

Notes - 2003

Because of personnel shortages due to a state hiring freeze, the lead program is unable to provide us with data for this measure. Hopefully, they will be able to do so next year.

Notes - 2004

In order to standardize NH lead program rates with other states and CDC, the definition of the age group for this measure changed from 18-29 months to 24-35 months. This change was made for the data beginning with 2003, and has been made for the WORDING of the measure following the needs assessment year.

a. Last Year's Accomplishments

The Child Health Nurse Consultant worked with the Program Manager of the Childhood Lead Poisoning Prevention Program (CLPPP) to develop a policy change and subsequent memo sent to MCH Title V contract agencies regarding a change in EPs automatically being done on all lead screening samples sent in to the state lab for lead analysis. (IB)
The (CLPPP) staff attended one of two annual MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates. (IB)
MCH required its contract child health direct care and primary care agencies to screen all enrolled two year olds for lead as part of its contract Exhibit "A" Scope of Services, and audits this at agency site visits. Policies for scheduling, tracking, and follow up of abnormal lead screening results were reviewed as part of the agency's administrative site visit tool component. (IB)
Child Health Services in Manchester, an urban MCH contract Child Health agency, continued to receive targeted CDC funding from CLPPP as part of its MCH contract, to do lead case management on all of its children identified with an elevated lead level. (IB)
MCH required its contract child health direct care and primary care agencies to include performance measures pertaining to screening both one and two year olds for lead in their annual workplans submitted to MCH for the upcoming fiscal year, as well as the completed workplan (with descriptions of whether agency targets were met, and why/not) for the previous year.
The MCH Child Health Nurse Consultant participated in the CLPPP Medical Consultants Group and the CLPPP Advisory Committee. (IB)
Refugee children are eligible for Medicaid upon arrival in NH. During the fiscal year, 212 African refugee children were resettled in Manchester. Of these, 109 (51%) had initial screening (capillary) and follow-up (venous) blood lead testing. This testing identified 39 African refugee children (36%) who had elevated blood lead levels (BLLs =10mcg/dL) on follow-up testing (median: 14 mcg/dL, range:10-63 mcg/dL). In comparison, of non-refugee children routinely screened in Manchester in calendar year 2003, 4% had elevated BLLs. Refugee

children who had not been tested according to state recommendations for blood lead testing in refugees were identified and tested. Those with elevated BLLs received appropriate follow-up care according to standard protocols. An MMWR article was published on January 21, 2005 describing this cluster of refugee children with elevated BLLs to alert public health officials in other states in which African refugees are settled of this potential public health issue (Centers for Disease Control and Prevention. Elevated Blood Lead Levels in Refugee Children. MMWR 2005; 54(02); 42-46).

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor MCH Title V contract agencies' screening of two year olds via site visits, annual agency performance measure reporting and accompanying workplans.				X
2. Share information updates with Title V-funded agencies via mailings and meetings.				X
3. Continue CDC-funded lead case management at one high risk MCH contract agency.				X
4. Continue participation in CLPPP Advisory and Medical Consultant groups.				X
5. Continue training to Home Visiting and HCCNH consultants.				X
6. Publish revisions to NH Childhood Lead Poisoning Screening and Management Guidelines and distribute to child health direct care and primary care agencies.				X
7.				
8.				
9.				
10.				

b. Current Activities

The CLPPP became a program under MCH as part of DHHS re-organization changes which promotes even further collaboration between staff. (IB)
The (CLPPP) staff attend one of two annual MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates. (IB)
MCH continued to require its contract child health direct care and primary care agencies to screen all enrolled two year olds for lead as part of its contract Exhibit "A" Scope of Services, and audits this at agency site visits. Policies for scheduling, tracking, and follow up of abnormal lead screening results are included in the agency's administrative site visit tool component (IB)
Child Health Services in Manchester, an urban MCH contract Child Health agency, continues to receive targeted CDC funding from CLPPP as part of its MCH contract, to do lead case management on all of its children identified with an elevated lead level. (IB)
MCH requires its contract child health direct care and primary care agencies to include performance measures pertaining to screening both one and two year olds for lead in their annual workplans submitted to MCH both for the upcoming fiscal year, as well as the completed workplan (with descriptions of whether agency targets were met, and why/not) for the previous year. (IB)
The MCH Child Health Nurse Consultant continues to participate in the CLPPP Medical Consultants Group and the CLPPP Advisory Committee.(IB)
The CLPPP provides information on screening in all Medicaid enrollment packets. (PB)

The CLPPP epidemiologist continues surveillance on testing of refugee children and alerts providers when refugee children are overdue for testing.

c. Plan for the Coming Year

The (CLPPP) staff will continue to attend one of two annual MCH Coordinators' Meetings to share with Title V funded Child Health and Primary Care information updates. (IB)
MCH will continue to require its contract child health direct care and primary care agencies to screen all enrolled two year olds for lead as part of its contract Exhibit "A" Scope of Services, and audit this at agency site visits. Policies for scheduling, tracking, and follow up of abnormal lead screening results are included in the agency's administrative site visit tool component. (IB)
Child Health Services in Manchester will continue to receive targeted CDC funding from CLPPP as part of its MCH contract, to do lead case management on all of its children identified with an elevated lead level. (IB)
MCH will continue to requires its contract child health direct care and primary care agencies to include performance measures pertaining to screening both one and two year olds for lead in their annual workplans submitted to MCH both for the upcoming fiscal year, as well as the completed workplan (with descriptions of whether agency targets were met, and why/not) for the previous year. (IB)
The MCH Child Health Nurse Consultant will continue to participate in the CLPPP Medical Consultants Group and the CLPPP Advisory Committee. (IB)
CLPPP staff will continue to provide training as needed on preventing lead poisoning to MCH Home Visiting agencies and HCCNH child care health consultants. (IB)
Continue promoting screening through Medicaid enrollment packets. (IB)

State Performance Measure 12: *Percent of infants born to women, whose payment source was Medicaid (for either delivery or prenatal care), receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	82	73	75	75
Annual Indicator	80.4	77.7	81.1	83.2	
Numerator	2110	1946	2199	2446	
Denominator	2623	2506	2712	2939	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

Notes - 2003

2003 vital records data is not available. It will be available for the 2006 application.

Notes - 2004

Data not available for 2004. This measure is being discontinued.

a. Last Year's Accomplishments

MCH-funded agencies continued to provide comprehensive prenatal care to low income, uninsured and underinsured women. The vast majority of patients in the funded agencies are Medicaid eligible women and children. (D, E)
MCH-funded Prenatal Program Coordinators' meetings continued on a biannual basis. These meetings provided a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered included oral health, medicaid compliance in billing practices for support services, and the development of performance workplans. (I,E)
Minority focus group information and a birth data report were completed in FY 03. Further analysis and development of a presentation were held throughout the hiring process of the MCHS epidemiologist in FY 04. (E, I)
A Performance Management Collaborative has been formed to create a comprehensive system of performance management across state and community systems. The collaborative is made up of MBCH staff and provider agency directors. (E, I)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to facilitate the MCH 2010 sub-committee of the New Hampshire 2010 Initiative. Objectives of the MCH 2010 Committee include promotion of provider cessation intervention with pregnant patients, alcohol screening in prenatal care settings, an			X	X
2. Continue to facilitate the Birth Outcomes Workgroup to develop and implement initiatives to reduce low birth weights in New Hampshire.		X	X	X
3. Convene community partners to reduce disparities in prenatal adequacy rates and poor birth outcomes based on identified socio-demographic characteristics.			X	
4. Continue to disseminate best practice interventions and updated guidelines among prenatal care providers within the publicly funded health center network.		X		X
5. Submit a PRAMS application to survey a representative sampling of New Hampshire women on health issues, status and experiences in pregnancy.				X
6. Continue to facilitate Prenatal Nurse Coordinator meetings.				X
7. Continue to meet with the Performance Management Team to coordinate provider site reviews.			X	X
8.				
9.				
10.				

b. Current Activities

MCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women. (D, E)
MCH-funded Prenatal Program Coordinators' meetings will continue on a biannual basis. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics to be covered at the FY 2005 meetings include: The 5A's model of prenatal smoking cessation; prematurity data and best practices; and performance management. (E)
The Prenatal Program will continue to explore options for implementing a PRAMS-like survey. The program's 2001 CDC application for PRAMS was approved but unfunded. The program is considering a one-time PRAMS survey for the City of Manchester in FY 2005. (P, I)
MCH will collaborate with the NH March of Dimes on a state-wide campaign to increase awareness of the health impact of preterm births and to promote early prenatal care. (P)
The MCH will implement a system of performance management across all MCH contracted agencies. The MCH will begin reporting on performance measures - both health status and infrastructure through a report card like format. (I)
Stakeholders within the Division of Public Health Services as well as community providers were brought together at an initial meeting of the Birth Outcomes Workgroup. The mission of the Workgroup is to identify strategic action steps that will lead to improved birth outcomes through targeted evidence based interventions. A particular emphasis will be on the recruitment and retention of prenatal patients in order to address adequacy of prenatal care and birth outcomes. Workgroup membership includes representation from; Division of Alcohol, Drug, and Tobacco Prevention, Women, Infants, and Children's Program, Medicaid Policy, community providers, the Minority Health Coalition, and Dartmouth Hitchcock Medical Center. (I)

c. Plan for the Coming Year

This measure has been discontinued.

State Performance Measure 13: *The percent of pediatricians who provide transition support to youth (ages 12-21)with special health care needs (YSHCN) enrolled in their practice.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	0	0	0	14
Annual Indicator	NaN	NaN	NaN	NaN	NaN
Numerator	0	0	0	0	0
Denominator	0	0	0	0	0
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective					

Notes - 2002

This is a new State Performance Measure. There is no Objective to meet and baseline data has to be identified. As such, a provisional "0" has been placed in all form fields.

Results from the National Survey of Children with Special Health Care Needs, 2001 (NSCSHCN), indicate that 51.7% of NH families with youth with special health care needs (YSHCN) report that "doctors have talked about changing needs as child becomes adult " (Summary Table IX.) and 41.1% report that "doctors discussed the shift to adult provider" (Summary Table IX.)

This data implies that over 50% of NH doctors seeing YSHCN have NOT discussed the changing needs and/or the transfer to adult health care services. SMSB will conduct a Pediatric Providers Transition Survey (FY04) to determine the baseline data and to develop Annual Objectives for this SPM.

Notes - 2003

FY03: This State Performance Measure had not yet been created. The issue was identified as a priority need and the measure was added to the FY04 application.

FY04: Initial baseline data for FY04 was determined by responses to an online survey of members of the New Hampshire Pediatric Society. The survey was conducted to assess their current practices and needs regarding transitioning YSHCN ages 12-21. The survey response rate was 14%, which may be related to the use of an online process, or to factors such as the large number of pediatricians who practice at the tertiary centers and/or are not in primary care, and/or are not providing direct care to youth, and therefore did not return the surveys. Of those responding, 14% met the criteria for this measure. See the "current activities" narrative for this State Performance Measure, for the survey results.

Notes - 2004

SMS chose not to re-measure the percent of pediatricians providing transition support in their practices because SMS did not do a general educational effort to this group until the end of May 2005. At that time staff (Cahill) provided copies of tools and materials to about 100 pediatricians at the NH Pediatric Society spring meeting.

The current focus of attention regarding transition is on the New Hampshire Youth Health Care Transition Project and the three pediatric practices that are involved. The Work Plan requires formation of a coalition that will help design a statewide education process for pediatric providers.

This SPM is being retired due to SMS having received the Champions for Progress Incentive Award, which focuses on transition work with pediatric practices. NPM #6 is the umbrella for all SMS youth transition work, and other priorities for were identified for CYSHCN that will be addressed as State Performance Measures.

a. Last Year's Accomplishments

SMS staff recognized the need to assess the current status of health care transition activity and capacity for increased activity among pediatric practices in New Hampshire. A survey tool was developed to assess how members of the NH Pediatric Society were addressing the health care aspects of NPM # 6 (i.e., Youth with special health care needs will receive the services necessary to make transitions to adult life, including adult health care, work, and independence.) The survey, titled "Transitioning Youth With Special Health Care Needs to Adult Providers", was conducted on-line through the NHPS to its members in June 2004.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Working with NH pediatricians to increase their capacity to provide more comprehensive transition services.				X
2. Providing health care transition tools to NH pediatricians through targeted mailings and at NH Pediatric Society conferences.				X
3. Analyzing the results of the on-line survey of pediatricians to assess their current level of service re: health care transition and training needs.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Analysis of the Pediatrician survey was completed. Twenty-seven pediatricians responded. The SMS staff analyzed the collected data regarding what services pediatricians provided to youth in transition, specifically looking for six activities that are considered part of a comprehensive transition package. Results indicated that while almost all pediatricians provided the first, education about chronic condition management, few developed the second, a written health care transition plan. The remaining four transition-related services were: providing a medical summary, providing written information about transition, talking about how health care needs will change in adulthood and, discussing referral to adult health care providers. Only four of the respondents (14%) provided all six services to YSHCN in their practice most of the time. The survey also assessed the need for educational and technical assistance. Ten of the 27 pediatricians (37%) responding thought that access to in-office consultation to develop individual health care transition plans would be of significant benefit to their practices.

SMS staff (Cahill) and a NH Family Voices partner (Ohlson-Martin) are working with NH pediatric practices to increase their capacity to provide more comprehensive transition education services to YSHCN and their families. SMS received a Champions for Progress Incentive Award from the Early Intervention Research Institute at Utah State University to assist in this endeavor (refer to NPM # 6). In December an educational and recruitment mailing was sent to a targeted group of NH pediatricians, sharing with them the tools that are recommended and soliciting interest in consultation about transition. Five practices expressed an interest and three were chosen to participate in the project, which was started in January 2005 and will continue until June 2006. An important outcome of the project will be to identify a cohort of adult providers interested in caring for transitioning youth.

Transition education packets were provided to participants at the NH Pediatric Society meeting in May 2005 and a display board contained additional information.

c. Plan for the Coming Year

This SPM will be retired and activities related to it will occur under the NPM #6.

State Performance Measure 14: *The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			2300	2300	2500
Annual Indicator		2,275.9	2,510.8	2,305.6	
Numerator		2008	2254	2113	
Denominator		88230	89772	91645	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2500	2500	2500	2500	2500

Notes - 2002

1) Most recent data available from Vital Records is calendar year 2001.

2) Vital Records calendar year 2002 data will not be available until the next grant application period.

Notes - 2003

Most recent data available from Vital Records is 2002. 2003 data will be available for the next application.

Does not include deaths. Passengers or drivers of cars only, i.e. does not include motorcycles. Also does not include "Person not otherwise specified" or "Person not elsewhere cited".

Notes - 2004

CY04 data will be available next year.

Does not include deaths. Passengers or drivers of cars only, i.e. does not include motorcycles. Also does not include "Person not otherwise specified" or "Person not elsewhere cited".

a. Last Year's Accomplishments

Buckle Up New Hampshire Coalition: The Coalition continued to meet on a monthly basis. For the annual conference in April of 2004 and during the annual Buckle UP NH week in May, youth programs that educate their peers on proper seat belt use were highlighted. (P & I) Injury Prevention Data Report and State Plan: In September of 2003, "NH Injuries, 1999-2001" was released by the Bureau of Health Statistics and Data Management and the IP Program. A sub-committee of the Injury Prevention Program's Advisory Committee met after that to determine model recommendations on reducing death and injury due to motor vehicle crashes for both the IP Program's state plan and for Healthy NH 2010. In September of 2004, this advisory committee met to begin to discuss ways of implementing the draft plan. (I) Intersections Project: The Intersections Project continued to meet looking at ways to link

programs addressing related risk factors and driving. (P & I)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor data trends in adolescent motor vehicle injuries.				X
2. Continue Buckle UP NH adolescent driver component.		X	X	X
3. Continue to participate in the Intersections Project.				X
4. Seek new partners for the Adolescent Motor Vehicle Legislation Committee to explore legislative options.				X
5. Publish Injury Prevention State Plan.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Policy: A Seat Belt Legislative Committee was formed to introduce and advocate for a seat belt law, in this case a secondary one. The bill was defeated in the House Transportation Committee. The group continues to meet to evaluate their efforts. (I)
Injury Prevention Data Report and State Plan: Final editing work is being done on the Injury Prevention Program's State Plan. A new surveillance manager was hired and is currently increasing injury surveillance capacity. Continuation of the Core Injury Surveillance Grant was written, submitted to the CDC, and is currently waiting approval. (I)
Buckle Up New Hampshire Coalition: The Coalition continues to engage adolescent groups in addressing seat belt use. It again highlighted adolescent outreach in its recent May of 2005 conference. The Coalition is currently looking into developing a health communications campaign advocating seat belt use along the line of " I always wear a seatbelt, who wouldn't". (P)
Intersections Project: Intersections continues working with partners regarding impaired driving as it affects adolescent drivers and passengers which culminated with a conference looking at medical fitness guidelines for driving, which took place in December of 2004. A bill to establish a medical advisory committee on driving was initiated in the legislature and is awaiting final approval from the House (P & I).

c. Plan for the Coming Year

Policy: The Adolescent Motor Vehicle Legislation Committee will seek new partners to explore legislative options based on data and best practice programmatic research. An expanded legislative coalition will again explore the feasibility of introducing legislation with respect to a primary seat belt law. (I)
Injury Prevention Data Report and State Plan: The Injury Prevention Program's Final State Plan will be coming out in fall of 2005. (I)
Buckle Up New Hampshire Coalition: The Coalition continues to engage adolescent groups in addressing seat belt use and is looking to set up a train the trainer model in effective, best practice models. (P)
Intersections Project: Intersections will continue working with partners regarding impaired driving as it affects adolescent drivers and passengers. Another annual conference has been

scheduled for September of 2005. Additional funds are being sought after to develop training for EMS providers on injury prevention and specifically, traffic safety in adolescents (P & I).

State Performance Measure 15: *Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			39	39	35
Annual Indicator			39.1	35.1	35.1
Numerator			9594	9451	
Denominator			24547	26930	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	35	35	35

Notes - 2002

This is a new measure. Data is from Medicaid - Patricia Fostier (271-8820).

Notes - 2003

Data is from Patty Fostier - 271-8820.

The accuracy of the data for 2003 is questionable, due to concerns about coding accuracy at the local level. We will explore this issue with EPSDT.

Notes - 2004

Actual data not available at this time, due to incomplete reporting from Medicaid. This data should be available in time for the 2005 autumn update.

a. Last Year's Accomplishments

The MCH continued to monitor the MCH contracted primary care agencies to assure adolescent specific health services are available and appropriate. (IB)
In FY04 the program continued to fund the provision of comprehensive teen health services to Manchester youth through the Teen Health Clinic. (D)
The Adolescent Health Strategic Plan was completed and was sent for review and approval for publication. Contained within the plan are clearly articulated rationale, background information and final recommendations on the need for responsive health care services for youth. The approval process took longer than expected and the plan was not disseminated in the summer of 2004 as scheduled (I,E)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sub-contract adolescent Health Services to Manchester Teen Clinic and more agencies as funding allows.	X			X
2. Continue monitoring the performance measure at the Manchester Teen Clinic and other MCH funded agencies.				X
3. Distribute copies of the Adolescent Health Strategic Plan to community organizations and organizations serving youth.	X			
4. In partnership with LEAH (Leadership Education in Adolescent Health) at Children Hospital in Boston, Dartmouth Hitchcock Medical Center, and the NH Pediatrics Society organize one-day workshop on adolescent health for providers.		X		X
5. Search and disseminate evidence based practices and other clinical guidelines to providers working with the adolescent population.				X
6. Participate in sites visits to MCH funded agencies to be organized by the MCH Quality Assurance consultant to ensure that adolescent specific services are provided.				X
7. Encourage and support initiatives for CYM looking at assessing community assets for youth and encourage the use of the adolescent health strategic plan in that process.				X
8.				
9.				
10.				

b. Current Activities

The Title V funded Teen Clinic in Manchester is providing comprehensive screening and assessment services based on nationally recognized guidelines to adolescents in need of services, including those eligible for Medicaid. We encourage all funded primary care agencies that an adolescent-focused health risk assessment is performed on all clients soon after entry into care and is updated at annual health maintenance visit. (D)
MCH and SMSB staff work together to ensure that all youth, including those with special health care needs receive the recommended periodicity of well care. (IB)
MCH partly funded training on Community Youth Mapping (CYM) organized by UNH cooperative extension and to benefit community partners working with youth. The project to implement a CYM is being initiated in two communities under the direction of UNH Cooperative extension and the Adolescent Health Program is involved in that project and will continue in the future. (CB, IB)
MCH just completed a need assessment that showed that adolescent clients has poor health outcomes in some areas such as access to regular and comprehensive primary care services, nutrition and wellness and mental health services. (IB)
Additionally, our quality assurance program has conducted sites visits in some MCH funded agencies and noticed a need to build a specific focus on adolescent health in primary care in order to promote healthy behaviors and access to health care services. (IB)
As a response to those identified needs, the adolescent health program revised the performances measures for the Teen Clinic in Manchester to include assessing and addressing obesity, and encourage enrollment in Medicaid for eligible youth. (IB)

c. Plan for the Coming Year

Our plans for next year include disseminating the Adolescent Health Strategic Plan and

encourage stakeholders at the community level to use that tool to develop activities that promote adolescent health and positive youth development in general. (IB)
The Adolescent Health Program will work with our partners to develop and fully implement a grass root Youth Advocacy Network and community tool kit for communities and coalitions interested in creating youth health initiatives. (IB)
We will work with MCH data team to disseminate the results of our needs assessment and adolescent specific data to create awareness of adolescent specific health needs. (IB)
We will also promote the use of evidence-based clinical practices whenever possible and we will provide resources and clinical guidelines if needed. (IB)
The Adolescent Health program will continue and strengthen our partnership with the department of education to develop the Coordinated School Health Plan and build a new relationship with School Based Health Clinics. (IB)
The adolescent health program will encourage and support MCH funded agencies and other primary care agencies in NH to build a focus on adolescent health in their practices to improve the delivery of appropriate primary care services to their young clients. (E, IB)

State Performance Measure 16: *Percent of children ages 2 – 5 years enrolled on WIC whose Body Mass Index (BMI) for age is 95th percentile or greater.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			15.4	15	15
Annual Indicator			15.1	15.1	
Numerator			1021	1021	
Denominator			6754	6754	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	15	15	

Notes - 2003

This was a new measure for the 2005 application. Data for 2003 is estimated and 2004 data is not available. This measure is being discontinued.

Notes - 2004

This was a new measure for the 2005 application. Data for 2004 is not available. This measure is being discontinued.

a. Last Year's Accomplishments

The WIC Nutrition Consultant presented on childhood overweight/obesity and use of the BMI at the fall'03 meeting of the Title V funded agencies' child health coordinators and distributed packets of the Pediatric Weight Management Tool Kit developed by a state committee. (IB, PB)

BMCH printed a new supply of growth charts for the Title V funded agencies that now includes the BMI chart for the 2-20 population. (IB)
The fall '03 packet of the Child Health Month Coalition included a handout on "Sip All Day, Gain Weight, Get Decay" which was distributed to over 5,000 health, childcare, social service, and school health providers. (PB)

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Child Health Month Coalition included a handout for its fall '04 mailing on Healthy lifestyle/exercise/preventing obesity. (PB)
MCH distributed via email a newsletter to its contract agency from the NH DHHS Bureau of Health Promotion with suggestions on promoting healthy eating and exercise. (PB)
Through the Title V Needs Assessment process, MCH and SMS identified childhood obesity as a priority and decided to end its current obesity-related performance measure and replace it with a new one that may have more far-reaching impact. (IB)
MCH staff added use of BMI to its primary care agency chart audit tool and has been monitoring this at recent site visits conducted. (IB)
The MCH Child Health Nurse Consultant met with staff from the Bureau of Health Promotion to enhance collaboration and share resources developed on nutrition and fitness that could be shared with MCH contract agency staff.
MCH invited WIC staff to share their data on the Pediatric Nutrition Surveillance Survey (PEDNSS) and the Prenatal Nutrition Surveillance Survey (PNSS) at the spring'05 meeting of Title V funded Child Health and Prenatal Program Coordinators and at the June MCH staff meeting. (IB)

c. Plan for the Coming Year

This performance measure is being discontinued, and replaced with another that supports the priority of addressing the childhood obesity problem in New Hampshire.

E. OTHER PROGRAM ACTIVITIES

In addition to previously mentioned activities, the following come under the purview of NH's Title V program:

PRESCHOOL VISION AND HEARING SCREENING PROGRAM (PSVH): Program staff and trained community volunteers have provided hearing and vision screening and follow-up for preschool children statewide since the 1960s, targeting low-income families without easy access to affordable health care services. Declining enrollments in screening clinics and staffing constraints prompted MCH to re-evaluate this program in 2005. A PSVH Advisory Group was convened, and plans are underway to transition this program away from direct care model toward the provision of technical assistance and community level infrastructure building over the next year.

NEW HAMPSHIRE BIRTH CONDITIONS PROGRAM AT DARTMOUTH: Dartmouth Medical School, SMS, MCH, WIC, and Early Intervention continue to collaborate on the implementation of a birth defect surveillance system for NH. Funded through a CDC cooperative agreement, the project is: establishing a high quality, statewide, active, comprehensive birth defect surveillance system; expanding NH folic acid education and birth defect prevention activities; and improving access to health care and early intervention services for infants with birth defects. The MCH and SMS Directors are active members of the project's Advisory Council. MCH provides support as appropriate, such as development of the MOU between DHHS and Dartmouth, and a letter outlining the project to encourage hospitals' cooperation with data sharing and surveillance activities, given the lack of a New Hampshire statute requiring reporting of these conditions.

MCH ADMINISTRATIVE RULES DEVELOPMENT: New Hampshire Administrative Rules describe the responsibilities and required activities for external agencies with regard to state law. MCH is revising its administrative rules to address Newborn Screening and Early Hearing Detection and Intervention Program requirements. Originally slated for 2004, this project was delayed until needed legislation related to the NSP is approved, as described in Section IIIB.

FAMILY RESOURCE CONNECTION (FRC): MCH contributes to braided funding for this information clearinghouse for families, administered through the New Hampshire State Library. Begun in 1998, use of the FRC has tripled over the past 5 years. From July through November 2004, the program received 959 inquiries and 1,496 circulation requests. While 69% of inquiries were from professionals, requests from parents/families comprised slightly over 20%. The subject of inquiry for most requests was "multiple topics", but 13% related to early childhood education, 16.4% to disabilities, and 16% on parenting. The MCH Director and an SMS staff member participated in a planning session for sustainability of this resource in 2005.

"BRINGING THE CHILDREN HOME" is a grant-funded project of the Visiting Nurse Association Health System of Northern New England, Inc. The goal is to develop a new pediatric care delivery model to bridge the gap between inpatient pediatric care and the growing demand for pediatric home care services. SMS staff (Landry) sits on the advisory committee, informing the group of services and resources available through SMS and the State of NH.

EMERGENCY PREPAREDNESS: The MCH Administrator participated in pertinent public health emergency preparedness efforts during 2005, including National Incident Management System training.

HEALTHY NH 2010 WORKGROUPS: MCH staff co-chaired several HNH 2010 workgroups in 2005, as discussed in Section IIIA. The MCH workgroup will implement action steps in the year ahead supporting the five MCH Performance Measures.

NH CHILDREN'S TRUST FUND (NHCTF) PERFORMANCE & EVALUATION COMMITTEE: The MCH Child Health Nurse Consultant, a board member of the NHCTF, chairs this committee which includes reviewing activities related to quality assurance, grant making, and coordinating the Board's programming decisions.

CONSUMER PRODUCT SAFETY COMMISSION (CPSC): The Injury Prevention Program is the state liaison to the CPSC. As such, the program raises awareness of product safety throughout New Hampshire by providing information and compliance programs, including compliance reviews for

recalled products.

FALLS PREVENTION PROJECT: The Injury Prevention Program brought together twenty groups to address elderly falls. Groups are comprised of professionals working with elderly who currently live at home, with hospitalized elderly, and with those in long-term care settings, such as nursing homes. The project began with a conference to provide an intensive exposure to best practices in falls risk reduction and prevention. It also connected participants with NH Falls Risk Reduction Task Force members and other colleagues from around the state. Each group is paired with mentor task force members who will work with them for an additional year post conference. Each group will also learn how to create a model database and track falls indicators.

STATE TOLL-FREE NUMBER

The State maintains a toll-free number for all DHHS services. This computerized, menu-driven system links callers directly with the program area best qualified to respond to their question. Operator backup is included, for those needing operator assistance, and hearing impaired persons can utilize TTY/TDD Relay. Several regionalized information and referral systems complement the State toll-free number. The CSHCN program maintains its own telephone line for information and referral and supports the toll-free number provided through Family Voices. Help lines for CSHCN processed approximately 1200 calls in calendar 04. Inquiries for SMS are also responded to through the State's web-based information system for NH DHHS.

F. TECHNICAL ASSISTANCE

TECHNICAL ASSISTANCE FOR MCH:

I. Visioning Process

Why assistance is needed: With the 2006 Title V Block Grant, MCH has undertaken an extensive process to identify the health needs of MCH populations in New Hampshire and capacity needs to address health concerns. It is widely accepted that successful, efficient and effective organizations operate under the umbrella of a cohesive, shared vision. MCH has taken some initial steps in developing a vision, but has not completed the process. The Division of Public Health Services (DPHS) is also planning to undertake a visioning process within the next year. Subsequent to the recent DHHS reorganization, MCH priorities compete with additional issues within DPHS, such as bioterrorism, drug and alcohol prevention and treatment services, and community public health network development. MCH would like to take a leading role in the DPHS visioning process by providing a facilitator for this process. This will help assure that the MCH vision is aligned with the overall DPHS vision. Technical assistance is required to assist with the following activities:

· Meet with MCH and DPHS staff to develop a plan for the visioning process.
· Review current MCH and DPHS repositories of information to be used for establishing benchmarks in preparation for the visioning process.
· Conduct a brainstorming visioning session to identify common goals, beliefs, and drivers for this effort.
· Conduct key informant interviews to obtain feedback and input into the final draft vision.
· Conduct a final review session with stakeholders to validate the final vision.
· Develop an implementation plan for the newly crafted vision.
· Conduct 3 and 6-month follow-up sessions to assess post-implementation input.

Developing a vision for MCH that is aligned with the DPHS vision will assist the Section to address all performance measures by:
1. Assuring that MCH strategies are integral to the overall DPHS vision
2. Assisting key Title V managers in developing a shared understanding of their basic purpose, strategies and values; and
3. Enhance MCH's visibility both within and external to DPHS.

Who could help: Deloitte Consulting, LLP

II. Funding Allocation & Funding Formula Development

Why assistance is needed: The MCH allocates funds to programs and community agencies based primarily on historical funding levels. The previous formula for funding allocations occurred prior to 1995 and centered on regional levels of children in poverty and prenatal health data at that time. Subsequently, many changes have occurred in New Hampshire's health care delivery system, such as the development of community health centers in several areas of the state, changes in geographical service areas, and achievement of FQHC status for six agencies. Technical assistance is required to assist with the following activities:

· Review current Title V funding allocations as they relate to federal MCHB priorities, specifically direct, enabling, population-based, and infrastructure services provided by the Title V program.
· Provide information and instruction on principles of funding formula development in public health programs to MCH, Family Planning Program and Bureau of Rural Health and Primary Care staff.
· Assist the MCH in consideration of factors likely to impact state and community level programs' funding needs, such as regional poverty levels, population density, performance measures and health outcomes.
· Assist the MCH in developing a proposed funding formula for contract agencies that reflects Title V priorities and communities' needs.

Developing a funding allocation strategy and funding formula for MCH contract agencies providing direct care and enabling services will assist the Bureau to:
4. Plan effectively and economically for population-based and infrastructure services provided by the Title V program
5. Assure an equitable and evidence-based distribution of Title V funds; and
6. Move the MCH further towards a performance-based contracting system.

III. Youth Development Integration

Why assistance is needed: The MCH currently lacks the capacity to adequately measure how well the programs and services we support impact youth development. Further, programs across the NH DHHS lack common language and focus with regard to youth focused programming. Technical assistance is required to assist with the following activities:

· Within the MCH and Bureau of Rural Health and Primary Care, develop youth development language for RFPs and contract Scopes of Services to ensure delegate agencies address these concerns within workplans.
· Develop outcome and performance measures reflecting youth development language, including how to assess development in clinical chart reviews.
· Assist the MCH in discussions with the State Youth Collaborative (SYC), an inter-agency working group whose members represent HHS programs that impact youth, to develop common youth development language for all HHS contracts.
· Assist the MCH and SYC in developing common outcome and performance measures reflecting the new youth development language.

Developing common youth development language for MCH and HHS contracts will assist the Bureau to:
1. Institute a new Title V state-negotiated performance measure;
2. Leverage the NH YRBS to include protective as well as risk factor questions;
3. Enable contract agencies to report on new and potentially more useful outcomes; and
4. Move the NH DHHS towards a more coordinated system of adolescent health programming that reflects current best practice knowledge.

Who could help: The National Adolescent Health Information Center; the Konopka Institute for Best Practices in Adolescent Health; the state of Iowa; the state of Alaska; the state of Maine; the Rochester Evaluation of Asset Development for Youth (READY); RMC Research, developers of the Compendium of Assessment and Research Tools for Measuring Education and Youth Development Outcomes (CART).

IV. Injury Prevention Best Practices

Why assistance is needed: While there are many environmental and regulatory strategies known to be effective in reducing unintentional injuries, such as the use of child passenger safety seats and helmets during a variety of sports, much less is known about how to increase adoption of long-term behavioral changes among those at-risk. The Injury Prevention Program is committed to theory-based educational activities, utilizing theories such as the health belief model, stages of change, and peer diffusion. Technical assistance is requested to assist the Program to identify best practices in improving the use of motor vehicle restraints in the adolescent population.

Technical assistance is requested to conduct a literature review and develop best practices recommendations to:
· Increase adoption of seat belt usage for teens ages 14-19
· Technical assistance in training community teams to address seat belt usage by teens in their communities
· Follow up TA quarterly over a one year period to assist community teams in implementing an action plan to address this issue

Who could help: Dr. Carolyn Fowler, Johns Hopkins School of Public Health; University of Alabama School of Public Health

V. Oral Health Educator Position

Why assistance is needed: Dental care in this country is provided by private and safety net systems of care independent of medical primary care systems. As a result, children who are followed for their primary medical care typically do not have oral health issues addressed by their care provider. One of the greatest challenges in improving oral health is better coordination of the medical and dental systems. In NH a pilot project is educating physicians about oral health by training pediatricians and family physicians to screen young children for dental disease and make referrals to local dentists for treatment. However, professional boundaries, time, and attitudes are barriers to accessing dental treatment for young children in need. A dental hygienist called an Oral Health Educator could facilitate cooperation between the medical and dental professions to improve the oral health of young children. In medical offices, Oral Health Educators can teach physicians about screening young children for dental disease, and counsel parents about behaviors that promote dental disease as well as encourage feeding practices and nutritional changes that can assure a lifetime of oral health. Using established relationships with local dentists, oral health educators will refer families with young children for dental treatment and educate dental professionals in their offices about how to manage young children.

Technical assistance is required to assist with the following activities:

· Conduct a literature review for examples of the Oral Health Educator role in other states
· Develop a formal job description for the Oral Health Educator
· Develop protocols for adding an Oral Health Educator to a medical practice
· Provide a marketing plan for such a position to improve acceptance by both medical and dental professions

Who could help: Dr. Burton Edelstein, Director of The Children's Dental Health Project in Washington, DC. He has recently released a white paper, "The Interface Between Medicine and Dentistry in Meeting the Oral Health Needs of Young Children"; Early Head Start Programs that have difficulty

accessing oral health care for their 0-3 population; Home Visiting programs that incorporate oral health into a curriculum for high-risk pregnant women.

TECHNICAL ASSISTANCE FOR SPECIAL MEDICAL SERVICES (CSHCN Program)

Special Medical Services (SMS) is requesting technical assistance, consultation, and facilitation to conduct a formal Section-level strategic planning process regarding care coordination services. This request is in accord with all identified priorities for NH CSHCN, all National and State Performance Measures for CSHCN, and Health Systems Capacity Indicator #08.

Assistance is needed to help guide the SMS staff in the identification of the technology, policies, and funding strategies necessary to achieve the goals of SMS. Special Medical Services offers infrastructure-building expertise to develop the NH systems of health care for CSHCN, in balance with the direct provision of community-based care coordination.

To fully actualize the principles of family-centered, community-based care, both the direct provision of service by state coordinators, and the provision of consultation to other public and private providers, is crucial. Facilitated planning will encompass the priorities and needs of NH CSHCN, their families, and the provider community. The core issue is the defining of future applications of the SMS care coordination model and determining the nature and extent of direct care coordination services provided by SMS staff and contractors, within the overall CSHCN health care system. Defining exactly which CSHCN subpopulations, which geographic areas of the state, what family impact factors, eligibility criteria, and other such specifics, is necessary in order to target the limited resources to the identified priority needs in the most effective manner.

The strategic planning will include issues of Medicaid reimbursement, the cost of providing care coordination in medical homes, enhancement of data capacity, policy development, health information exchange, applied research, and workforce development. The individuals suggested to provide the facilitation and consultation are well-known experts in the MCH/public health field, with specific expertise regarding health policy and services for CSHCN and their families. It is believed that SMS would greatly benefit from having this external expertise to guide the planning process, similar to the productive experience SMS had with the recently facilitated CAST-V process. SMS expects the development of state-based care coordination leadership to significantly impact the future availability and quality of care coordination for CSHCN in New Hampshire, and to assure access to the services to those families most in need.

V. BUDGET NARRATIVE

A. EXPENDITURES

SIGNIFICANT EXPENDITURE VARIATIONS APPEARING ON FORMS 3-5

For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:
The expended amount on Line 8, Other Federal Funds, shown for FY 2004 was less than 10% of the budgeted amount, due to delays in accepting those federal grants into the state budget as well as delays in staffing projects during a state hiring freeze.

Form 4:
Line Id: The expended amount for CSHCN was greater than budgeted amount by 17%, due to one anticipated SMS contract that was not approved, and reductions in other SMS contracts during that SFY.
Line If: The increase in the expended amount for Administration is due to a change in the formula used to calculate this line using the job code system.

Form 5:
Expended amounts in Line III differs more than 10% from the budgeted amount for FY 2004 as a result of inclusion of the Injury Prevention Program budget being added to the MCH appropriation after the program transitioned, and due to certain cost allocation expenses not being included in the original budgeting process.

New Hampshire implemented a job code system in 2000. Assignment of job codes permits calculation of expenditures in a more detailed fashion than was previously feasible. All expenditures, including personnel, supplies, equipment, and contractual, use job codes reflecting classification as expenditures related to specific grants or programs, in order to draw the correct percentage of Federal vs. General funds. This allows for accuracy in reporting expenditures for Financial Status Reports and Award Histories.

Unfortunately, limited job codes are permitted under the NH system, prohibiting the creation of enough codes to also classify expenditures by types of individuals served and by pyramid levels. These expenditures will continue to be calculated by formula applied to expenditure reports according to line item.

B. BUDGET

HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL EFFORTS

Federal support is essential to the preservation of a comprehensive Title V program in New Hampshire. The Title V Maintenance of Effort and required match help assure a basic funding level for state and local maternal and child health programs. During times of necessary fiscal constraint, difficult decisions must be made about decreasing or eliminating programs and services. In these situations, Title V block grant dollars work to remind all states of the importance of funding MCH activities.

Aside from State funds, other monies are also leveraged by these Federal dollars for MCH services at both the state and community levels. For example, Title V dollars help fund the New Hampshire Family Resource Connection, a clearinghouse and library service, administered by the State Library on issues related to maternal and child health. For this initiative, $5,000 MCH dollars are combined with additional funds from the Child Care Development Fund, Department of Education, Division of Behavioral Health, Division of Developmental Services, and Division of Children, Youth, and Families

to fund the project. Another example of the leveraging power of Title V funds is the proposed plan for Child Care Health Consultant services. MCH funds for this project ($50,000) are leveraging additional monies from New Hampshire's Immunization Program ($15,000), CLPPP ($10,000) and SMS ($5,000) and will likely result in additional funding once the pilot project is complete.

At the community level, Title V dollars help fund numerous local agencies and projects that provide a wide variety of services to MCH populations. In these communities, Title V dollars also help leverage funds from municipalities, businesses, and private foundations to serve the Title V mission. Often, simply the fact that an agency contracts with MCH gives them increased credibility with other funders and an increased ability to leverage funds from small, community foundations, the United Way, or other fundraising efforts.

AMOUNTS UTILIZED IN COMPLIANCE WITH THE 30%-30% REQUIREMENTS

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMS; $925,000, or 44.79% of New Hampshire's Title V allocation, is appropriated to the SMS budget for FY 2006. Preventive and primary care services for children are provided through the MCHS; costs include direct care and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCHS children's services. The total of $816,442, the amount projected for FY 2006, is 39.54% of the Title V allocation.

HOW ADMINISTRATION & MAINTENANCE OF EFFORT ARE MAINTAINED

Administration: This amount is projected using calculations from prior years' cost allocation reports on a specific job code that identifies administrative expenses required to carry out this grant.

Maintenance of Effort: The Title V Block Grant Maintenance of Effort requirement is one factor considered when planning the MCH and SMS budgets. The budget development process includes incorporation of the Title V Maintenance of Effort amount in calculating appropriation requests.

ACHIEVEMENT OF REQUIRED MATCH
The required State match for Federal Title V dollars is achieved through state general fund appropriations to the MCH and SMS budgets. The state budget is determined by a legislative and gubernatorial process on a biennial basis. The budget development phase involves formulating specific line item requests within MCH and SMS appropriation codes. For example, most MCH personnel costs are a combination of Federal Title V and State General Fund dollars. Similarly, most equipment, supply, travel and contractual line items are shared between Federal and General Fund allocations. Once the Biennium Budget has been approved, the exact Title V match can be determined.

New Hampshire is currently undergoing the process of approving the state budget for SFY 06 and 07. For the purpose of this application, NH House budget figures were used to calculate budget amounts for FY 2006. New Hampshire's projected combined State General Fund appropriation to MCH and SMS for SFY 2006 of $6,419,828 is 311% of the FFY 2006 Title V allocation of $2,065,063.

STATE MAINTENANCE OF EFFORT & STATE FUNDS USED

New Hampshire continues to exceed the Maintenance of Effort requirement. The state FY89 Maintenance of Effort {Sec. 505(a)(4)} of $2,872,257 is compared to the projected FY 2006 Title V budget of $8,484,891, of which $6,419,828 is from State General Funds.

SOURCES OF OTHER FEDERAL MCH DOLLARS, STATE MATCHING FUNDS & OTHER STATE FUNDS USED TO PROVIDE THE TITLE V PROGRAM

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child

Health Bureau (MCHB) and other Federal agencies. Only MCHB grants are discussed below:

SSDI Grant: $100,000
These funds are used to address New Hampshire's capacity to improve performance on Health Systems Capacity Indicator #09A and to develop linkages between MCH program datasets and New Hampshire birth files.

Abstinence Education Grant: $94,901
These funds are being used for community grants to implement abstinence-only curricula.

Universal Newborn Hearing Screening Grant: $120,000
These funds are used to establish New Hampshire's universal newborn hearing screening program, including implementation of quality assurance standards and a data-tracking initiative.

ECCS Grant, CISS Program: $100,000
This grant is used to fund a strategic planning project for early childhood comprehensive systems. This planning project is in its final year, and will address strategies to strengthen the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood.

All State matching funds, as indicated on Form 2 and explained previously in Achievement of Required Match, are appropriated from the New Hampshire General Fund during the State's biennium budget process.

Due to the configuration of New Hampshire's public health infrastructure and its system of contracting with local agencies to provide MCH services, there are no sources of "Local MCH" or "Other State" funds included in the MCH or SMS appropriations, as indicated on Form 2.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

For the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:
No budgeted amounts FY 2006 differ more than 10% from amounts for FY 2005.

Form 4:
Lines Ia, b, e, and f: The decrease in budgeted amounts for "Pregnant Women" and "Infants< 1 year old" in FY2006 by 12% and 11% respectively are due to the increase in "Administration" of 465%, resulting from the use of a new methodology for calculating this amount, as discussed in Section VA. The increase in the budgeted amount for "Others" is in part due to the increase in the proportion of men and elderly clients seen in MCH-funded community health centers, and estimated amounts in the State's Catastrophic Illness fund.

Line IIk: The decrease in budgeted HCCA funds is due to the completion of this grant.

Form 5:
No budgeted amounts for FY 2006 differ more than 10% from amounts for FY 2005.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.